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ME Psychol.

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The National Committee for Mental Hygiene

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The National Committee for Mental Hygiene, directly and through its affiliated state societies and local committees, works for the conservation of mental health; the reduction and prevention of mental and nervous disorders and defects; the improved care and treatment of those suffering from mental diseases; the special training and supervision of the feebleminded; and the acquisition and dissemination of reliable information on these subjects and on mental factors involved in the problems of education, industry, delinquency, dependency, and others related to the broad field of human behavior. The committee seeks to accomplish its purposes by stimulating research into the nature and causes of nervous and mental diseases and defects; conducting surveys and studies of mental-hygiene problems; applying the knowledge gained from such studies, through education and the promotion of beneficial legislation; encouraging psychiatric social work; establishing child-guidance and other mental-hygiene clinics; developing trained personnel; and coöperating with governmental and unofficial agencies whose work touches at any point the field of mental hygiene.

When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.

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THE DYNAMICS OF THE RELATION OF PHYSICIAN AND PATIENT

WILLIAM A. WHITE, M.D.
Superintendent, St. Elizabeths Hospital, Washington, D. C.

THE law of supply and demand has many more subtle manifestations than those with which we are ordinarily familiar in the domain of economics. Not only may we explain by it the fluctuations in the price of commodities and the flow of labor to and from industrial centers, but the very substance of social institutions springs from its operation. The institution of medicine and its representative, the doctor, are the matters in point that interest us here.

Medicine and the doctor have come into being as a result of the law of supply and demand. The demand has arisen as the result of man's desire to go on living, his wish for immortality, and this demand has been met by the birth of medicine and its incarnation in the doctor. This might be illustrated in many ways, but the most obvious illustration is the existence of laws that provide punishment for the doctor if he fails. Man not only wishes to go on living, but he will not even acknowledge death as a necessity if he can help it and so bolsters up his faith in his ability to ward it off by punishing the man temporarily intrusted with this power if he fails.[1]

[1] Of course it is to be understood that the separation of the wish to live from all other tendencies and its consideration apart from them is purely arbitrary and justifiable solely because of the practical advantages of so doing. That the wish to live contributes some of its strength to other tendencies and in turn receives some from them is undoubtedly true. Separations of this sort do not occur in nature, and largely because of that fact nature is so infinitely complex that separation is a necessary precondition to any effectual intellectual handling of these complex situations. That this separation is artificial and fictitious is of course fundamental, but that fact by no means destroys its value. It is necessary, however, to keep its true significance in mind.

Without undertaking to fortify this point of view by further illustration or by a development of the history of medicine from this angle, I will proceed on the assumption that the state of affairs as I have put it is self-evident once it is brought to attention. The necessary implication of this assumption that man's wish for immortality has been the force that called medicine into being is that, expressed in terms of energy, the energy at the disposal of this wish or desire must be very great indeed, and further that it is this fundamental desire that represents the dynamic assets of the patient with which the doctor has to work and that constitutes the greatest source of the doctor's power.

Of course, it has long been known that the desire to get well was an invaluable asset to the doctor in serious situations, but there has never been any adequate appreciation of the real dynamics of the situation, even sufficient appreciation to cause its serious study to be undertaken. While the power of the doctor to encourage the patient and to fortify his hopes has long been known, it has been thought of in such vague terms as the "personality of the physician", his "impressiveness", or the "power of suggestion", while no really consistent or scientific effort has ever been made to ascertain how best the doctor might mobilize this great power to the best advantage of his patient.

The first real light on this situation was thrown by psychoanalysis in its study of what has come to be known as the transference, and it is to some of the results of this study that I desire to call attention in their applicability to general medicine. This great spring of energy, which comes to the surface as the desire to live, is the very medium in which and with which the physician works. The dynamic relationship between patient and physician represents forces of undoubtedly great power, which, like all forces, may be turned to good or ill. The physician, while spending his entire life working in this field of energy, can be said hardly even to know of its existence, certainly if by "know" we imply any exact or accurate information. It would seem that the time was here when it would be profitable to undertake a serious and scientific study of this energy field. It might well come to pass, to my way of thinking, that such a study would

disclose forces of quite as great value to medicine as have recently been found in radio-activity, light waves, or other forms of energy. Let us see how we might approach the subject and what we might expect to find.

To understand what this means, it is necessary to have a comprehension of what is involved in terms of energy, in the concept of the intra-psychic conflict as it has been developed by psychoanalysis.

Mental development takes place, not as a smooth, unhampered progress from simpler, more primitive types of thinking, feeling, and acting to more complex, higher, and more efficient types, but, on the contrary, only as the result of overcoming, mastering, sidetracking, or otherwise circumventing the lower or more primitive tendencies which always offer themselves as alternatives to every course of thought and action, particularly if that course is not clear and unequivocal, but difficult and doubtful. These opposing tendencies represent quantities of energy, and to the extent that they are opposed in any particular situation, energy is wasted, in the opposition, that might otherwise be available to either side of the conflict.

This conception of the nature of the intra-psychic conflict is not peculiar to the affairs of the mind, but applies wherever energy is active; it is represented in the law of physics that action and reaction are equal and in opposite directions. Energy in motion always meets opposition, and in applying this law to mind it remains only to define the two directions: namely, the direction that leads to simpler and easier solutions—by analogy, the degradation of energy—and the direction that lies in the way of the creative tendencies, upward to more adult, complex, efficient, and satisfying results.

The solution of the conflict lies, in the one case as in the other, in reducing the amount of energy loss from the mere opposition of the two tendencies—in physics the reduction of the amount of friction—and so making the maximum amount of energy available for the end in view. In the mental realm this is brought to pass by uniting the two tendencies that are at cross purposes in an end that is mutually satisfactory. It is the same problem, in other terms, that we are familiar with in nervous physiology as the choice of the final common path, and in physics as the resolution of opposing forces.

A simple illustration, so many of which psychoanalysis has made familiar, will make the principle clear. A man who has a definite homosexual tendency finally makes a great success of his life in salvaging submerged members of his own sex. Pulled in one direction by a tendency that, unimpeded, would lead to definite antisocial conduct, he finally gives play to this tendency in a work of devotion to his own sex, but of a definitely constructive and creative character that is distinctly socially acceptable and so brings him a considerable reward in the way of respect from his fellows. The two tendencies have been brought to union for a common purpose. It is to be noted that this union is on a higher plane than the conflict. It is obviously on a higher plane than the lower tendency, and if this lower tendency were merely suppressed in favor of the higher, the result would be such a loss of energy in keeping up the repression that the subsequent conduct would suffer seriously in consequence. The union, therefore, results in the greatest possible efficiency.

Every one is more or less, of necessity, in a state of intrapsychic conflict. Conflict is at the very foundation of life itself and of mental life as well. Progress takes place only by the overcoming of difficulties, the surmounting of obstacles. Health, both mental and physical, is the result of conflict that has been successful on the constructive side of the energic balance, while sickness is the reverse. Sickness always, therefore, from this point of view represents the degradation of energy, its flow to lower levels, and so, in terms of effort, represents a solution in the direction of the easier way; it is not constructive or creative, it does not succeed in surmounting obstacles, it is not successful.

The balance toward health is never so overwhelming that it may not be reversed, and, once reversed, its tendency is to stay reversed. Illness tends to mobilize all the tendencies that lead in the direction of the degradation of energy and to the final outcome in a state of equilibrium in death. The object of therapy, from this point of view, is, therefore, to recapture the energy that is flowing in this direction and turn it to useful work in the opposite direction.

It now becomes clear why I laid emphasis upon the desire for life, which created the physician to serve its ends, and

why I designate this desire as the fundamental dynamic asset with which the physician must work. No therapeutic problem could offer more to repay investigation. The dynamics of this relation between patient and physician is the energic medium in which therapeutics has its being and through which its problems must be worked out if they are to come to their best solutions. Let us see something of the way this problem seems to work out from what little we at present know regarding some of the factors involved.

In the first place, speaking generally, people differ enormously in the formula of their energic life balance. Some have very much more energy engaged in the backward pull than others. These differences are based, among other things, upon their life history, their past experiences, and express the amount of premium that has been offered, in their particular life experiences in the past, to these obstructive tendencies. Some people, as it is said, never grow up, but continue all their lives to try to exact from the world what they want or think they want by methods that, while they may have worked well once when they were children, are no longer effective now that they are adults living in a world of adults. They may try, for example, to get what they want by crying for it, just as they once cried for the moon, and they must as inevitably fail because they have not learned that crying is not an effectual method of accomplishment.

These backward, dragging tendencies are always of this sort. They represent ways that, while they may once have worked, are nevertheless ways that should have been abandoned and left behind on the path of progress towards more developed methods. They, too, are the ways that are mobilized by illness, for in illness we all tend to become again as little children, dependent upon those about us for intelligent care and guidance.

At this point we begin to see something of the nature and form of the pattern man used when, through his desire to live, he called into existence, as a result of his great need, the physician and made him the trustee of his health and life.

The child in its helplessness meets all its serious difficulties by an appeal to its parents, with never a doubt, no matter what its extremity of need, that its appeals can be fully met. It

regards the parents as omnipotent and therefore able to rescue it from any situation that threatens. The physician can be easily seen to represent, in the patient's feelings, the parent in this aspect of his power to make everything all right again, to conquer illness, even death itself, and it is in this capacity of parent image that he has access to that well of energy which I have designated as being represented by the desire to live.

Let us call this energy of which I am speaking psychic energy. It is familiar to us under many names—libido, love, respect, confidence—and it has been hotly argued that the use of the term energy in this connection is wholly unwarranted, principally because it cannot be measured as can the energy with which we are more familiar in the domain of physics. This argument may not be satisfactorily answerable, but it is my contention that the use of the term energy to describe what happens in the psychic realm is practically justifiable because it enables us to think about those happenings and to visualize them in ways that are useful to us in trying to understand what is taking place. I like to think of the whole problem of health and disease in this way, not simply in terms of bodily organs and the visible, ponderable changes that may be wrought in them, but as the complex resultant of forces that play from within and from without the organism and produce here and there tensions and stresses, but that are always tending toward some satisfactory resolution in the direction of equilibrium. From this point of view, what is the nature of the problem under discussion as it confronts the physician?

Naturally I cannot undertake to discuss the bearing of this point of view on all the different types of therapy—chemical, physical, surgical, serological, and so forth. I am endeavoring to outline an hypothesis which applies to all and which particularly stresses the importance of the psychological component in all illness. To make it clear, I will briefly retrace the steps we have taken thus far and recall the dynamic situation—the relation existing between physician and patient.

In the first place, we have seen that the patient feels toward the physician much as a little child, looking up to him as a source of great power and helpfulness in his extremity and trusting in him to bring him through. On the other hand, the attitude of the physician toward the patient is the obverse of

this. He accepts the rôle thrust upon him and tends to believe in himself and in his power to accomplish that which is expected of him. These attitudes, let it be understood, are quite unconsciously assumed by both, and largely because of that fact any failure in the desired results is apt to be quite as unacceptable to the one as to the other; *per contra* success tends to support the belief in the correctness of the rôles projected by each on the other and assumed willingly for opposite reasons. The patient is willing to assume the rôle of child because that relieves him of all responsibility and puts it on the shoulders of the physician; the physician assumes the rôle of omnipotence because that flatters his vanity and feeds his will to power.

Herein lies the most fundamental of all therapeutic artifacts, because the whole dynamics of the situation is below the threshold of conscious awareness and works out its results quite unconsciously. The patient is generally quite willing, because of his trust in the physician—and perhaps because of his secret sense of cleverness in having chosen him—to believe that he was cured by the particular drug administered by the physician, and the physician is equally convinced that he cured the patient by the means he chose to apply. Thus it has come to pass in the annals of medical history that every therapeutic measure has at one time or another been credited with the cure of almost every human ill, a state of affairs that will go on repeating itself as long as the factors involved remain unconscious.

So much for the negative side of the situation. How about the positive side?

Just as illness tends to mobilize the destructive forces, whatever they are, in each particular patient, so the desire to live is a force of opposite sign which can be mobilized in the service of health. What can be done in this direction?

If the physician is ignorant of the dynamics of the situation, he may still function effectively intuitively and it is of such stuff that many a great physician is made. But he is always in more or less danger of doing the wrong thing or of leaving the right thing undone.

In the first place, the physician should know very much more than he now usually knows about the actual personality

make-up of his patient in terms of just exactly what is the nature of both his assets and his liabilities in the sense of tendencies that make for life or for death. It may be quite as important to know the psychological formula of the patient in this sense, when it comes to treating him for a pneumonia, as to know which lobe is involved and the exact stage of the disease and the form of the invading microörganism.

A consideration of the patient, not solely as a human being with a consolidated lung, but as an organism in the sense of an energy system, will help, for it will prompt the physician to think in terms of energy and how to mobilize it or reinforce it rather than deplete it. It will suggest when sympathy and kindness, solicitude, and a meticulous interest in details are necessary and when severity, brusqueness, indifference, or harshness may best be used.

I am not thinking here in terms of suggestion. Suggestion is a catchword which is used with great freedom, but few if any know what it really means. It stands for a form of psychological influence about which, in the last analysis, only too little is really known, despite the long time it has been in use, the extent of that use, and all that has been written about it.

I am thinking more in terms of the parent-child relationship of the physician and patient and the mechanism of overcoming obstacles by the uniting of the energies of opposing trends.

The physician should be able to tell with some show of accuracy when the energies are depleted to such an extent that no further demands should be made upon the patient and when they have become sufficiently reinforced so that something more can be expected. This seems like a simple formula and one well known, but it is only known in the simplest of its manifestations. In this world of mind things are not always what they seem and mental symptoms often mislead because they are parading under false colors.[1] The formula really means that the physician should take the psyche of his patient much more seriously into consideration than he usually does, and that, therefore, he should be able really to evaluate the mental aspects of the situation during illness.

[1] The distinction between manifest and latent content, as the psychoanalysts put it, is what I have in mind.

The state of the patient, as an energy system, the extent of energy depletion, and so the degree of energy need are the points of importance, for they serve to indicate certain considerations on the part of the physician.

If the patient is seriously involved and quite unable to make the grade alone and unaided, the physician should be quite willing to assume the rôle of the omnipotent father and add energy to the situation through love and sympathy and a painstaking, patient, and obvious attempt to help in every way possible. When the patient begins to get better, the physician may begin to assume the rôle of the more severe parent who insists that his child shall begin to stand on his own feet. This again sounds rather simple, but here we find ourselves right at the very root of the whole matter.

This attitude of the physician cannot be artificially assumed, put on and taken off like a theatrical make-up. Back of the attitude must lie sincerity of purpose, for unless it does the real objective will show through, whatever camouflage may be used. The patient may not be able to grasp the situation intellectually or to formulate it in language, but intuitively he will apprehend it, with effects accordingly. Pretense may have its day, but it is always skating on thin ice and must give way when sincerity comes along.

Of course I do not mean that the physician should consciously feel toward the patient as father to child. He is able to effect all the results that might be so attained by re-symbolizing his own child-father feeling components and residuals and nucleating them all in his profession. Medicine becomes for him at once his child that he wishes to see develop and succeed and his master (father) that demands of him certain standards of conduct and of achievement.

Perhaps I have said enough to make my meaning clear—I hope so. The result of it is the call for the entrée of the psyche (mind) on the field of medicine with a status equal to that of the soma (body). Unless this equality is once for all conceded, I have tried to show how it will ever be impossible to evaluate the results of therapy because of failure to take into consideration the psychic component and the consequent creation of all sorts of artifacts.

Just an illustration to serve as a suggestion of how the

dynamics of the transfer serve to bring to pass all sorts of situations, both good and bad, and alike out of control of the physician so long as the whole process remains unconscious.

The most obvious results of the situation are the "cures" that from time to time have been attributed to every conceivable agency. Drugs, climate, water, air, heat, cold, electricity, magnetism, exercise, rest, diet, surgery, have all, in the past, been credited with producing effects we now know them incapable of. Hardly a drug in the pharmacopœia is without a history of "cures" that we know it is impotent to produce. It is idle and superficial to dismiss all this evidence, with which the history of medicine is so replete, by designating the "cures" as "fakes" and frauds and the illnesses as imagination. The remedies were administered often by sincere practitioners of medicine and the patients as often were really ill. The fact was that the patient got well, but the explanation that it was due to the remedy was wrong. The recovery was due to the fact that the forces making for health and represented by the desire for life and health had been mobilized by the dynamic situation of the transfer. This explanation applies even to surgical procedures. It not infrequently happens that a patient is cured or improved by a surgical procedure, though nothing wrong was found at the time of the operation.

If all this is so, then it would seem obvious that the psychological component of illness needs recognition and study in order that we may have at our command added ways of mobilizing the forces that make for health.

The principles herein set forth are applicable to all human relations for they are all dynamic, all take place in an energy field. It is only needful to shift the *dramatis personæ* from doctor and patient to nurse and patient to read the same lesson for the nurse as has been outlined for the doctor. The outstanding importance of character in these two professions is thus made evident in a much clearer way than usual, and the qualifications needed are more nearly capable of being reduced to specifications, or at least we can feel that we know something of what it is that is basically needed, even if we may not know as yet just how to define it, find it, or even always to recognize it when it is present, for character traits

masquerade in many and often strange disguises. It is at least evident that the whole matter is worthy of the most painstaking study.

When all this is taken into consideration—and in addition the natural tendency of the great majority of illnesses to get well spontaneously—we begin to see how fallacious must be the majority of reports on the curative effects of various forms of treatment. An adequate evaluation of the sources of error in medical thinking, of the nature of the artifacts that result from the entrance of given fallacious factors, and of the best correctives to apply is sorely needed. Just a single illustration in closing will make this clear.

Contrary to what might be our *a priori* thought on the subject, the chronic invalid is the most fertile source of testimonials as to the efficacy of various "cures". Epilepsy and locomotor ataxia furnish good instances in point. Any form of therapy will help these patients. Their need is so great that they grasp at the vaguest hope and force themselves, so to speak, to believe that they have finally discovered the solution to all their woes. At such a psychological moment they will honestly testify in the most glowing terms to the value of the remedy on which, for the time being, they are resting their hopes. In fact, the epileptic will characteristically tell you that he is getting better, even though nothing is being done for him at the time. The wish mechanism is strong enough to function unaided. Now if, with a potent wish for health, there comes into the picture a physician with a commanding personality and a form of treatment the virtues of which he extols, and particularly if he (the physician) believes in those virtues himself, it is not difficult to understand why and how the patient is carried along, on the wings of desire, to improved health. The end result is of course not changed by all this, but much valuable time and effort could have been saved if the factors of error had been appreciated from the first instead of having to be relearned each time.

PSYCHOANALYSIS AS GENERAL PSYCHOLOGY*

OTTO RANK

Vienna

I TAKE it for granted that you have already heard of psychoanalysis and I assume that what you now wish to know is whether you are thinking about it in the right way. I can, of course, tell you only what I think about it. To begin with, I do not know how you came to know of it, from what angle each of you has looked at it, or in what sense you have taken it—I mean whether you think of it as a therapy for the treatment of nervous sufferings, or as a method of investigation of the unconscious life, or as a psychological theory.

In any case my purpose is to present psychoanalysis to you from a general point of view and from its purely practical side. In other words, I want to show you what we to-day can take from psychoanalytical knowledge, how it is possible to apply this knowledge in the various spheres of practical life, and what advantages we can gain thereby.

As far as possible, I will not dwell upon the mere historical development of psychoanalysis and will also try to avoid discussing it as a theoretical system. Both these phases of the subject have been satisfactorily handled in psychoanalytical literature, and I could give you nothing more about them than you can get from that literature. First of all I want to dispose of a number of obsolete ideas about psychoanalysis which I think are rather in the nature of misunderstandings than actual deficiencies in your knowledge of it. Then I purpose showing you how psychoanalysis appears to me to-day, what in a certain sense it has accomplished, especially what practical contributions to life it has made and has still to make. If we once realize the significance of psychoanalysis for our present social life, we shall at the same time get some idea of the important part it has to play in the near future.

But I must at least give you briefly the most important

* Read before the Pennsylvania School of Social and Health Work, Philadelphia, June 19, 1924.

facts from the past of psychoanalysis, so that you may know whence it comes and what it purposes. Psychoanalysis was born in the year 1881. Its father was the late physician, Dr. Josef Breuer, who for nearly ten years kept secret the birth of this illegitimate child. Dr. Breuer then abandoned the child because it might appear a bastard of scientific medicine, of which he himself was a representative, and of psychotherapy, which is still under suspicion at the present time. It was then that it found a tender and loving foster mother in the person of Sigmund Freud. He reared the neglected and misunderstood being, and developed it into what we know to-day as psychoanalysis. It is now full grown and self-reliant. It leaves behind it a very interesting past, and has gone through many adventures which Freud himself has recounted up to the year 1914 in his *History of the Psychoanalytic Movement*,[1] and has since brought up to date in some of his later encyclopedic articles.

In order to be able to understand psychoanalysis fully, as it is to-day, we must—according to a fundamental principle of psychoanalysis itself—grasp the determining phases of its childhood. Breuer's discovery was of a purely practical nature. It had, so to say, been made at the bedside of a patient, and was the result of a compelling necessity to give therapeutic help. At that time it could not be called psychoanalysis. The name psychoanalysis was introduced many years later by Freud himself, and definitely given to the method of investigation and treatment which he himself had developed. The story of Breuer's first case has already been related so often that it will be enough here to recall just its essential points. It was to this case that he owed his surprising discovery, and also his method of therapeutically influencing the patient. This patient was a young girl who had suffered from a number of hysterical symptoms since she had nursed her father in a severe illness. Breuer, under certain conditions which he later called hypnoid, was able to bring back to her consciousness certain forgotten memories. The content of these memories gave meaning to the symptoms—that is, the symptoms were revealed to be substitutions

[1] English translation by A. A. Brill, M.D. New York: Nervous and Mental Disease Publishing Company, 1917.

for the memory of a painful incident which, because it was painful, had been forgotten. The symptoms thus dominated the patient's consciousness in place of the forgotten incident. She called the relief that she obtained in her hypnoid states from remembering the forgotten facts the "talking cure" or, jokingly, "chimney sweeping". This related also to the fact that she remembered so-to-speak "repressed" English, which she had not spoken since she was a child and which she now spoke exclusively. This unburdening of soul became the basis of Breuer's kathartic method, and it was this that Freud later developed into the psychoanalytic therapy. The surprising fact was that the symptoms apparently disappeared as soon as the forgotten impressions were brought into consciousness or remembered. This problematical state of affairs formed the starting point for a number of investigations which finally led to the analytic psychology.

Starting with Breuer's first case, let us disregard the therapeutic factor and follow the development of the psychoanalytic psychology formulated by Freud, which has become the first normal psychology, in spite of the fact that it was developed from pathologic material. For this purpose we must give a little further consideration to Breuer's katharsis, as the affect-toned remembrance of forgotten impressions was called.

You remember that the symptoms proved to be substitutions for forgotten painful experiences—that they disappeared as soon as the original impressions had been brought again to the patient's consciousness. Thus the therapeutic task seemed quite easy. It looked as if one had only to consider how to find out those recollections which had expressed themselves so inappropriately as symptoms. This was possible only by bringing the forgotten experiences to the remembrance of the patient, and the easiest way to do this seemed by direct questioning in hypnosis. The patient herself was the stimulus for the development of this method. She sometimes fell quite spontaneously into hypnoid states, in which she was able to recall forgotten memories. Breuer tried later to induce this state artificially by hypnosis in other patients who did not produce the same symptom of hypnoid states. As a matter of fact, hypnosis, with its hyperamnestic quality, led to practically the same effect. And it is to be regretted that Breuer

did not make full use of his discovery in this direction, although probably in that case we should have missed the discovery of the real psychoanalysis by Freud.

The story of why Breuer did not continue his investigation, which promised such success, is more than a mere anecdote; it is a specially interesting fragment of the history of the science. We know that he was able to show an undoubted success in the treatment of his first patient; the symptoms disappeared apparently with the explanation of their origin.

But something else not noticed and not understood by Breuer appeared in the patient in place of the symptoms. This was appreciated by Freud only much later, and was the foundation stone of his psychoanalytic therapy as well as of an understanding of the neuroses. The story is this. As Breuer one day revisited his patient, at that time almost recovered, he found her again in bed, in a state of excitement accompanied by violent convulsions whose meaning he had not long to look for. His patient cried out to him that she was now bringing forth the child begotten by him. This was enough to horrify any respectable doctor. Consequently he, so to speak, suddenly forgot his cue, took the matter personally, declared the patient insane, and arranged for her to be put into a mental hospital. There, after some time, this acute condition died away of its own accord.

Do not let us reproach Dr. Breuer for not realizing immediately that this curious behavior on the part of his patient was only a newly formed symptom in place of her neurosis, which, like her earlier symptoms, could be made to disappear by bringing into consciousness the real unconscious meaning of her reaction. I think the doctors among you would have treated the case just as he did before Freud had recognized in such behavior something typical, which he later, according to his dynamic conception, called by the name of *transference*. So you see Breuer did literally run away from psychoanalysis as from an unwelcome illegitimate child. And perhaps you can understand how even to-day, in spite of a complete psychological understanding of this phenomenon as the transference, psychoanalysis has won a certain sexual notoriety, which has deterred some of Freud's fellow workers since Breuer from further occupation with the subject.

But hypnosis, not the understanding of the transference, was the starting point of Freud's own method. He soon found that hypnosis was not appropriate for every patient. Besides, it had in its influence something vague, inexplicable, and mystical, so that he finally dropped it. He wanted to know, on the one hand, what occurs in the patient, and, on the other hand—also from practical motives—how one can help the patient without being dependent on the unreliable method of hypnosis. This second question could be answered only by learning more about the processes that go on in the patient, the mechanism of the mental life. And so a plan of inquiry was necessary, as also a series of investigations to answer the following questions:

1. How can one bring the forgotten pathological impressions back to the memory of the patient in his normal condition?

2. Why does he remember these impressions with such difficulty?

3. How is it that the symptoms disappear when he has remembered the repressed experiences?

The first question leads directly into the field of general psychology, involving as it does an investigation of the normal psychical state. This is accomplished by the real psychoanalytic method, based on free associations and their interpretation according to a quite determined unconscious aim. The second question—why it is that the patient remembers the impressions with such difficulty—leads from the phenomena of forgetting and remembering to the kernel of dynamic psychology—namely, the concept of *repression.* The third question—how it is that the symptoms disappear when their causation is remembered—leads finally to the doctrine of the *unconscious* and its predominating psychical mechanisms.

The real birth hour of psychoanalysis was that moment, nearly a generation ago, when Freud went beyond the questioning of the patient in hypnosis and began to investigate psychical mechanisms in the normal state. Then for the first time he got at an understanding of the normal unconscious processes, which finally led, through a special method of inquiry and investigation, to the psychoanalytic psychology.

Here, first of all, I must explain the manner and character of the psychoanalytic method. There are, properly speaking,

two methods, according to their essence quite different, from which Freud, having dropped the hypnotic therapy, built up the psychoanalytic method of investigation: (1) the method of free association, which has as its presupposition the strict determinism of all psychic occurrences; (2) the method of interpretation, which has so often been accused of being purely arbitrary. The first method, or free association, is actually a purely scientific principle, which can be experimentally demonstrated by the association test, wherein also the determinism of psychical occurrences is incontestably manifested. With the greatest possible elimination of conscious attention and self-criticism—which generally tests and sifts all ideas—these freely occurring associations betray a more or less conscious relation to a definite complex. The discovery of the unconscious site of the complex was in the beginning very difficult and accompanied by the usual uncertainties. One arrived at the hidden unconscious meaning alluded to in these associations really through a kind of intuitive guess work, in which one naturally would sometimes go wrong, but in which quite definite rules gradually crystallized into the so-called technique of interpretation. This interpretation appeared subjective and arbitrary only so long as one did not apply to it also the same law of the strict determinism of all psychical life.

By frequent experience we have gradually learned to trace the chain of associations further, link by link, into the preconscious and the unconscious, and so to recognize the psychical meaning of the entire process. This technique of, so to speak, translating was soon formulated into definite rules which for the most part have been since confirmed not only by the numerous clinical experiences of many analysts, but in part also by experiment. I think, then, that the interpretations of psychoanalysts have been justified theoretically as subordinate to the law of determinism, and have been practically confirmed from various outside sources, such as mythology, folklore, art, and so forth. For instance, symbolism has been demonstrated indisputably to have the same meaning in different spheres of the human psychical life. So the whole technique of interpretation, like the method of association, was only a method of investigation used to ascertain the

content and meaning of the unconscious psychical life which you now know under the names of various complexes, as for instance the *Œdipus*.

But the knowledge of all these unconscious complexes makes it superfluous for the analyst to-day to take the same difficult route in every individual case. That would be just as if every doctor had to make chemical experiments at the patient's bedside to work out the necessary preparation or medicine, which he can quite easily buy at a druggist's. To-day we are in a position to convert directly into practical use the results of a decade's laborious work in analysis. We can apply this knowledge not only to the therapy of neuroses, the field in which psychoanalysis started, but also just as well to the various fields of general psychology. Until recently the general psychological knowledge which we owe to the psychoanalytic method of investigation alone was still too limited to serve as a basis for satisfactory therapeutic results. On this account the enormous and as yet incomplete work of investigation was necessary. But now, armed with our enriched knowledge, we can set out in our struggle against neuroses; and not only against disease itself, for we can use our knowledge as a prophylactic by applying it to the betterment of child education and of our social and sexual relations through the psychoanalytic understanding of our own natures and characters. And the development of psychoanalysis has led to this spontaneously, without the drawing up of a program, because in its nature it is practical, real, and humane.

From this it should not surprise you that I have placed psychoanalysis as a general psychology in the foreground, and have put into the background its therapeutic function, which yet was the starting point of the entire work and to many appears still to be its essential feature. The disinclination of human beings to recognize the universal nature of the unconscious impulses brought to light by analysis—which it has become impossible any longer to ignore—has led to a conception that unfortunately has marred the image of psychoanalysis. Finally, the objection has been made: "All these immoral, egoistic, sexual tendencies may be found by analysis in the unconscious of neurotics, and may be answerable for their illness. But one ought not to generalize this fact and

extend it to the psychology of the normal." Such an objection seems to me like the answer of most children when they learn something of the facts of the sexual life. The child usually reacts thus: "That may be all right for so and so's parents or for animals, but for my parents, certainly not!"

Such is the objection to psychoanalysis! But such an objection, while characteristic and intelligible as a defense, is as a matter of fact—one might almost say unfortunately—false, for all the unconscious material brought to light by analysis in the treatment of neurotic patients, and recognized in their psychical mechanisms, proves on closer inspection to be a common possession of mankind. I said "unfortunately", not because I sympathize with the moral resistances criticized above, but from the scientific regret that we have been unable to isolate any specifically pathologic factors, and thus to simplify the problem of therapy. Our experience has been that it is a matter of quantity only; the neurotic becomes ill from the same conflicts that the so-called normal succeeds in mastering.

But we need not regret too much this failure to find something simple which could be easily understood, easily got at, and so easily cured. Instead, psychoanalysis has found something more valuable—a new understanding of the normal psychic life, based upon knowledge of the general psychological unconscious contents. These contents had not been recognized before, because no method existed by which one could trace them and bring them up into the light of consciousness, which one is obliged to do in the psychoanalytical treatment of neurotics, if one really makes an effort to help them. What Freud has formulated in his *Interpretation of Dreams,*[1] his *Psychopathology of Everyday Life,*[2] his sexual theory, his studies of civilization, ethnology, and æsthetics, is nothing but a normal psychology.

The kernel of this psychology is the doctrine of *repression,* which represents a psychical protection and defense mechanism of the ego against something incompatible with it. Let

1. English translation by A. A. Brill, M.D. New York: The Macmillan Company, 1913 (third edition).

2. English translation by A. A. Brill, M.D. New York: The Macmillan Company, 1914.

me illustrate the mechanism of repression further by a simple comparison which remains within the range of psychoanalysis. In repression the ego acts towards a wish impulse arising from within exactly as Dr. Breuer behaved towards the unwelcome message from without, which announced to him a child. The ego wishes to know nothing about it and attempts to turn aside from the idea by depreciating it or denying it. If this is not successful, one must at least confine it for a time in the unconscious, as Breuer did with his patient when he put her into an asylum. There in the unconscious the unwelcome wish impulse may be left after a while to its own resources without special supervision. This example illustrates the most favorable aspect of repression. But if by any chance one continually has to use a part of one's psychic energy to restrain or to keep guard over this unwelcome impulse or idea, or if the idea is strong enough and permanently rebels, then there is nothing left to do but call for help.

This illustration may give you at the same time an idea of the double consciousness which dominates our inner life and which becomes manifest only in severe cases of neuroses or psychoses. From the fact of repression, the dynamic point of view follows quite naturally to the assumption of something repressed, which strives against the repressive forces of the ego. But this division within the psychic personality need nót throughout occur between the conscious forces and the unconscious repressed forces; although the simplest case of repression is that in which an unpleasant idea is removed from consciousness into a less approachable level which we call the preconscious. Neither need it always be the ego and the sexual impulses that strive against each other; although very often the moral ego defends itself by the repression of a displaced sexual impulse. On the other hand, repression is neither the only method nor always the most appropriate method of inner psychical defense. There are several other means, as, for example, displacement, projection, and still others. But repression, according to experience, often fails, because it—presumably biologically preformed—mostly opposes the sexual impulses, against whose intensity the defense mechanism of the ego collapses.

The failure with regard to repression at important points

in the development of the individual has been recognized as one of the important causes of neuroses. But even a successful repression—such as the child has to accomplish from the day of its birth, for purposes of adaptation—maintains in the unconscious an underground life. This might be compared to the underworld in the Homeric poems, where dwelt the shades of the prematurely slain heroes, who could come to life again at any time by drinking blood. Thus, the fundamental law of repression is really the psychological counterpart of the physical law of the conservation of all matter. For in the psychical world, also, nothing can disappear without a trace, leaving no memories nor impressions nor affects! Here also, as in the physical universe, there can be only change, displacement, transformation.

But psychoanalysis has found also a number of normal psychic phenomena in which repressed wishes or thoughts are temporarily and partially fulfilled and which are recognized and understood in their importance for psychical economy—namely, as necessary outlets. These phenomena are our nightly dreams, in which the repressed wishes of the past, no longer allowed by the developed ego, return in a distorted, archaic form of expression, nevertheless subject to quite definite laws. The importance of dreams and of their understanding for the study of character and for human knowledge is now well known, since they grant us a wide insight into the unconscious life. But just as illuminating are the faulty acts or blunders of everyday life, such as slips of the tongue, forgetting, losing things, symptomatic and chance actions. The study of these various blunders leads to a general understanding of normal actions, especially such as are performed impulsively—for instance, writing letters, going for a walk, reading, and the like. But the blunders represent the neurotic symptoms of everyday life, and their occurrence in exaggerated form is due to pathological functioning in a process of general importance—namely, to faulty repression, which can be cured only by means of the therapy of "kathartic remembering". The, so to speak, purely private dream life, on the one hand, and the slight social errors on the other are the keys to an understanding of everyday psychology, which one can really describe as a psychology of forgetting and remem-

bering, or a psychology of memory. Indeed memory, that human quality *par excellence,* by maintaining useful or successful repression of inexpedient experiences, determines our relation to the outside world in the sense of culture-adaptation and culture-formation. The blunders of everyday life and the neurotic symptoms incompatible with social life relate to the outer world. The dream of our private life relates directly to the human inner world, and to the understanding of personality, of character formation, and of the phantasy life, on which are based even the highest accomplishments, such as religion, art, and to a certain extent even science.

The deepened understanding of everyday psychology which explains our relation to the outer and to the inner world, to reality, and to thought, led the psychoanalytic method of investigation to the first real conception of the psychology of the child. The differentiation between phantasy and reality that characterizes the cultured adult's attitude to life has not yet occurred in the child. Freud recognized the fact that children's dreams represent simply wish fulfillments. In other words, the child can represent as real (in the dream) his as yet unrestrained wishes without offending his still undeveloped ego and the higher moral and æsthetic claims. The faulty acts of the child have not been investigated, because, as I assume, there are none in the case of a little child, who lacks a firm relation to reality and the social order belonging to it. Indeed, from the point of view of adult adjustment to reality, one could describe the entire child life as a single faulty action, because the child constantly confuses reality and phantasy, forgets that it has to adjust itself, and speaks in such a way that the grown-up person either does not understand it or considers it funny. From the very beginning, the child needs somebody who will ever put before it and explain its relation to reality; somebody who will draw its attention to material objects, so that the child will not come into conflict with them—in the literal sense of the word will not knock up against them; somebody who will teach it to differentiate between thought and matter, and who will give it a language intelligible to others also. In other words, the child must constantly be reminded of the task of adjustment, which can be successfully accomplished only when the child loves the person who teaches

it. For successful adjustment, the child needs to identify itself with the loved person, and to be able to give its interest to the outer world through the medium of this model. Such a person we call an educator where a child is concerned, a psychoanalyst, in the case of an adult in whom complete adjustment has not been successfully effected. The means and ways by which we can attain this end are given us in pedagogy, which yet has much to learn from psychoanalysis, especially in the matter of understanding the relation between child and educator. This relation rests on love, which we have studied in analysis as transference and which we have also learned to use as a means of education and reëducation.

From the study of the phenomena of transference insight is gained into a wider field of normal psychology—namely, the sexual life. This has become the most disputed as well as the most generally discussed part of psychoanalysis which so decisively influenced our social standards with regard to our sexual life. To-day it is established that the sexual instinct no more enters into a human being at the time of puberty then the soul enters into the embryo, as was the belief of the Church Fathers. But we know that this instinct has a genesis, which is revealed in the famous libido theory. If one traces the development of the sexual instinct to its biological source, one finds that, considered from an individual psychological point of view, it is originally nothing else than a regressive libidinal phenomenon. The libido ultimately is nothing else than the desire to return to a happy primal condition, which the ego has once experienced and which individually can be nothing other than the prenatal state. From my own analytic investigations I have developed the concept that this blessed primal state is represented for the individual by the prenatal, intra-uterine state, in which the being was perfectly protected and completely gratified.

Through this concept of the libido as the tendency to regress to the mother, many problems—as, for instance, that of sexuality in the narrow sense—and all neurotic disturbances of this function become intelligible. From a dispassionate psychological standpoint, love is the way of satisfying this primal instinct, since one approaches most nearly to the primal reality when one comes into the closest possible physical contact with

a loved being, as one was once with the mother. Only, instead of the two fully developed egos, a third, just being created, accomplishes the real return to the mother. This temporary, although incomplete, satisfaction of the libido aim in the sexual act simultaneously serves the strongest regressive tendency of flight to the mother and the most intense progressive tendency—namely, the creation of children. The human being is enabled to apply the remaining portion of the still unsatisfied libido to necessary adjustments to reality and to the creation of culture, by using it in the service of sublimation. It would take too long to prove—and therefore I can only mention here—that a vast range of our general human culture is a product of libido sublimation. Even our highest psychical level, involving the thought process, is influenced by our instincts and acts in their service.

This knowledge has great practical importance also and belongs to the principles of psychoanalysis. Breuer's discovery of symptom formation has already shown that the academic psychology was wrong in supposing that certain ideas that come into consciousness are rigidly bound to the affects that appear at the same time. On the contrary, the affects show a great capacity for displacement along certain channels. The affects can be soldered to one idea, but just as easily freed again and bound to another. Above all, the study of dreams has shown that this is the case, not only with pathogenic affects, but that nearly all our emotions are, so to say, falsely interpreted by our consciousness or, to express it another way, are "inadequate", because they originally referred and still refer primarily to other objects and situations. Especially is this valid for the human being's two strongest affects, love and anxiety, which regularly are attached to persons in earliest childhood and can be only transferred later to others. A consequence of this analytic concept of the displacement of the affect which alone gives its value to the conscious idea was the recognition that the human being up till now had enormously overestimated his consciousness and especially its highest accomplishment, logical thought. The real driving, determining forces lie in the emotional life, which reaches with its roots into the depths of the unconscious.

As compensation for its depreciation of consciousness as the

driving force, psychoanalysis has on the other hand increased the power of consciousness as an instrument of knowledge. It does this by extending to an enormous degree the capacity of the human mind for self-observation in a field up till now undiscovered—namely, the unconscious. Consciousness, indeed, cannot govern the unconscious, but it can better recognize it and by means of this recognition can extensively control it. From this fact Breuer had already started. But it remains one of Freud's merits that he explored this purely therapeutic experience and revealed its general psychological importance. Psychology, which before had dealt only with the intuitive method of self-observation, was placed by Freud on a scientific basis, when he applied the method of objective and exact observation from the self to other people—the patients and human beings in general.

The *unconscious, repression,* and the *libido* are the three fundamental pillars of scientific analytic psychology—the libido as the chief motive power; the unconscious as the essential content, previously completely neglected; and repression as the fundamental defense mechanism of the psychical life. The latter has to keep the unconscious from the conscious ego and from reality. Dynamically expressed, repression guarantees to the adjusted ego protection from exaggerated claims, both of the libido from within and of reality from without. All three concepts are derived from a dynamic energetic point of view, and make for the first time a psychology that avoids the mystical soul concept of the philosophers and the materialistic conception of physiology. The scientific importance of the analytic psychology lies in three fundamental points of view:

1. Psychoanalysis not only maintains that all psychical occurrences are significant, but can give proof of this for the first time by taking the unconscious into consideration.

2. Psychoanalysis has thereby shown the strict determinism that rules in the psychic life.

3. Psychoanalysis has placed the whole psychic life under the general law of an unconscious aim, popularly called wish fulfillment, more accurately, perhaps, instinct satisfaction. This is subordinated to general laws of energetics in the psychic life, which should be valued as highly as the laws of nature

in the physical world. Recognition of the strict determinism of the psychical makes psychology a science. Recognition of the unconscious meaning of everything psychical leads to an unexpected enrichment of the mental sciences. Recognition of the unconscious aim tendency leads to an entirely new orientation of the human being in the world, to an intellectual revolution whose final goal is not yet to be seen. Finally, we shall gain an enormous extension of consciousness through raising the instinctive unconscious psychic contents to the level of conscious human thought. That means an essential stride in development which may even be considered comparable to a biologic advance of mankind and is an advance that will be accomplished for the first time under a certain conscious self-control.

THE KINDERGARTEN AS A MENTAL-HYGIENE AGENCY

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THE mental-hygiene movement, as we know it in this country, began with a major interest in the conditions and care of the adult insane. But by a logic that has frequently expressed itself in the progress of public health, this interest has widened to embrace border-line and normal areas, and has deepened to reach juvenile and early developmental levels.

The mental-hygiene movement was scarcely a decade old when it began to take an explicit interest in the mental welfare of children of pre-school age. This interest will undoubtedly become more systematic, and there will be an increasing utilization of community resources to further both the corrective and the preventive objectives of mental hygienists.

Of all these community resources the American kindergarten is one of the most interesting, and potentially of great influence. The kindergarten is often vaguely regarded as a kind of supplementary attachment to the public-school system, governed by the Victorian philosophy of Froebel, benevolent, but none too effective. It is difficult to generalize about kindergartens. Some, indeed, are dominated by a mystic symbolism out of touch even with the most elementary physical needs of their young children; other kindergartens, however, exemplify the nearest approach to ideal educational practice that can be found in our school systems.

The nursery-school movement has had a stimulating effect upon the kindergarten situation. It has demonstrated the possibility of rendering concrete physical and mental-hygiene services to children of both kindergarten and pre-kindergarten age. It is awakening kindergarten leaders to the necessity of a change in outlook and procedure.

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How can this change be brought about? By cumulative experiment and demonstration. The kindergarten has been singularly free from experimental study. After the educational authorities have purchased the piano and the supplies, they have been inclined to grant the kindergarten a somewhat detached freedom. Since, however, the kindergarten is really the recruiting station of the elementary school, it ought to be the most active and fertile field for experimental education and for child-hygiene activities. Prevailing practices tend to follow the same pattern with regard to age requirement, personnel, equipment, and program.

The kindergarten is consequently in danger of crystallizing into just another schoolroom, when to meet the new demands it should develop a versatile, multiple technique that will bring it into more effective contact with a wider range of childhood. Instead of becoming fixed as a schoolroom, the kindergarten should evolve into an educational and mental-hygiene service instrument, a kind of dispensary which will be staffed to do a certain amount of routine, but which will also be organized and geared to render special educational guidance to parents and to children of pre-kindergarten age.

The purpose of the present paper is to sketch, neither too abstractly nor too ideally, the possibilities of developing child-guidance activities within the kindergarten organization. The problem has been conceived not in terms of special classes or auxiliary schools, but in terms of special-guidance procedures.

EXCEPTIONAL CHILDREN OF KINDERGARTEN AGE

With the coöperation of the New Haven kindergartens,[1] the Yale Psycho-Clinic in 1923 made an exploratory census of educationally exceptional children attending the local kindergartens, with a total enrollment of 2,700. No effort was made to secure precise statistics through individual medical and psychological examinations. We planned instead to get the teacher's own estimate of her exceptional or problem cases in the month of May, after she had had several months of acquaintance with her pupils.

[1] We wish to make special acknowledgment of the assistance of Miss Jessie I. Scranton, late supervisor of the New Haven kindergartens, who was actively interested in the study and in its practical implications.

The schedule that was used is reproduced below. A score of various "exceptional" conditions were listed. The number of children reported for each group is indicated in brackets. Separate figures for boys (B) and girls (G) are given. It will be noted that superior children were included in the schedule. This was to remove the impression that we were chiefly interested in mentally deficient pupils. Although the hygiene and educational adjustment of the advanced or precocious kindergarten child constitutes a real problem, we shall confine this report to exceptional children belonging to the other groups.

TO THE KINDERGARTEN TEACHER.

We desire to make a simple census of the kindergarten children who are in any way exceptional from an educational point of view. Every kindergarten teacher is, therefore, asked to go over the entire register of pupils under her charge (both morning and afternoon) and to report by name and birthday every pupil who belongs to one of the four groups indicated below. Please be sure to add a few descriptive comments about each case. For example:

John Roger: Born March 23, 1918. Group 3-I.
He is slender boy of fairly normal appearance, but has a pronounced lisp and is very babyish in his ways and speech. Is not as independent as most of the other children. Cries very easily.

1. *Superior children:*
   - A. General ability (42; B 21, G 21)
   - B. Leadership (6; B 3, G 3)
   - C. Special gifts or talents (12; B 9, G 3)
2. *Children with special handicaps:*
   - D. Great difficulty in seeing (5; B 3, G 2)
   - E. Great difficulty in hearing (4; B 3, G 1)
   - F. Great difficulty in handling tools (8; B 5, G 3)
   - G. Cripple (10; B 6, G 4)
3. *Children with peculiarities of speech or conversation:*
   - H. Stammering or stuttering (5; B 3, G 2)
   - I. Faulty or indistinct articulation (20; B 16, G 4)
   - J. Baby talk (12; B 6, G 6)
4. *Behavior problems, conduct or discipline problems:*
   - K. Special fears, *i.e.*, terrified by dark, dogs, certain strangers, etc. (4; B 0, G 4)
   - L. Great shyness, timidity, undue silence, moodiness (27; B 17, G 10)
   - M. Stubbornness, spells of sulking (13; B 6, G 7)
   - N. Temper (3; B 1, G 2)
   - O. Unintelligent, slow to comprehend, possibly defective (40; B 25, G 15)
   - P. Inability to mingle with other children or coöperate in group work (6; B 3, G 3)
   - Q. Habit spasms, twitching of muscles of face, jerky bodily movements (8; B 3, G 5)
   - R. Sex habits (6; B 5, G 1)

S. Thumb sucking or other undesirable traits of any kind (3; B 2, G 1)
T. Enuresis (wets self) (5; B 3, G 2)
U. Nervous, easily excited (5; B 3, G 2)

School entrance status:

Not ready for school entrance, though of proper age	17
Ready for school entrance, but below proper age	48

No statistical or percentage deductions can be drawn from the above figures. They are purely indicative; but from the internal descriptive evidence which supplemented them, we may be sure that they do not give an exaggerated impression. The returns showed great unevenness in reporting "superior" children. It was clearly apparent that the kindergartners were less likely to recognize superiority than deviations in the opposite direction.

It is interesting to note that the proportion of exceptional boys is in excess of that for girls, the figures being as follows: for special handicaps, 17 vs. 10; for speech defects, 25 vs. 12; for behavior problems, 68 vs. 52. The number of cases in which the description was very suggestive of mental deficiency was 35, of whom 23 were boys.

Confirmatory and supplementary facts relating to the problem under consideration were secured through an investigation by Miss Isabel Kearny, a graduate student, who made a careful individual study of fifty unselected kindergarten children exactly five years of age. Her results are significant because they comprised a psychological examination, a school inquiry, and a direct interview with one or both parents of each child. Among the group of fifty children, there were three cases of faulty conduct, one instance of extreme, morbid fear, and three of malarticulation. There were also several cases of enuresis.

In connection with an investigation of pre-school norms of development, Miss Elizabeth Lord made a study of the home behavior of fifty four-year-old unselected normal children, ranging in intelligence from dull to superior (I.Q. 75 to 150). A record was made of all cases that presented personality or behavior problems. Minor, but by no means negligible problems were discovered in 18 out of the 50 children. There were three instances of enuresis, three of faulty food habits (including fastidiousness and vomiting), one of night terrors, two of tantrums, one of thumb sucking, four of excessively

inhibited speech, three of crying for long periods or too readily, and others of extreme shyness and fears. There is no way of classifying or indicating the seriousness of all these behavior problems. It is significant, however, that they are not confined to children of one intelligence group, but are widely distributed. Of the 18 cases in our group of 50, 5 fell in the "dull" group (I.Q. 75 to 83), 3 in the "bright" group (I.Q. 117 to 149), and 10 in the intervening average group.

Inhibition and resistance and shyness were found in varying degrees. In some cases this diffidence bordered on the abnormal and suggested strongly the socializing value and the preventive possibilities of the kindergarten.

A similar survey of the behavior characteristics of two-year-old and three-year-old children revealed a similar situation. In some cases special educational problems have clearly defined themselves even at this early age. In other cases there is ample evidence that future school problems are in the making and that the parents and children alike would benefit by a timely guidance.

Additional data concerning the problem of educationally exceptional children of pre-school age have come to us through cases referred to the Yale Psycho-Clinic for diagnosis and consultation. About one-third of all the cases referred to our clinic are children of six years of age or under. Among these are many cases who urgently need a modified kindergarten training adapted to their individual needs.

By combining the findings of the census of New Haven kindergartens, the results of the canvass of four- and five-year-old children in their homes, and the clinical records of problem children of pre-school age, we gain a fair idea of the magnitude of the problem of the educationally exceptional child, as it presents itself in the kindergarten.

It is somewhat more difficult to appreciate the importance or even the existence of unhealthy and abnormal conditions in children of kindergarten age than in children of elementary-school age. The kindergarten child is smaller, and the problems superficially are therefore smaller and appear less consequential. There is also a generous expectation that the child will outgrow his difficulties. From the standpoint of mental hygiene, however, these expectations are not always well

founded. And it is precisely for reasons of mental hygiene that special-guidance work for exceptional kindergarten children should be undertaken.

EDUCATIONAL CASE STUDIES

In order to define more clearly the possibilities of such special-guidance provisions, an intensive study was made of twenty-five kindergarten children in a foreign section of the city. All of these children were reported for consideration because of some handicap, defect, or peculiarity of behavior.

This study, which included a careful psychological and social survey of each child, was made by Miss Ruth W. Washburn. The data were secured in several different ways as follows:

1. A Binet-Stanford intelligence test given by the department of special classes.
2. A detailed psycho-clinical examination of each child.
3. A talk with the kindergarten teacher concerning the school capacity and school behavior of each child.
4. A visit to the home of each child.
5. Observation of each child's behavior in regular kindergarten group.
6. A talk with the principal of the school about the general conditions of the district.

The accompanying table (page 33) summarizes some of the major facts in these individual studies. Inspection of this table will show that 21 out of 25 of these children have parents who were born in Italy. In 88 per cent of the homes the Italian language is spoken. The language barrier works a special hardship on the child of kindergarten age. The difference between Old- and New-World customs in these foreign homes works an additional hardship and makes for poor adjustments in children of tender age.

In 7 out of 25 families the home conditions are classified as poor or very poor. In many of the homes the social and economic level is so low that the school has an increased responsibility in fostering normal social development at the kindergarten age. The home discipline frequently is in the hands of parents who use faulty and even pernicious methods.

As a result of these and attendant conditions, about one-half

SUMMARY OF STUDY OF 25 KINDERGARTEN CHILDREN IN FOREIGN SECTION OF CITY

No.	Sex	Age Yrs. Mos.	Mental status	PARENTS Nativity	PARENTS Approx. age	SIBLINGS No. older	SIBLINGS No. younger	Home conditions	Reason reported
1	B	4 — 10	1 year retarded	Italian	35–40	1	1	Good	Possibly defective; faulty articulation.
2	B	5 — 4	1 year + retarded	Italian foster parent	45–50	7	0	Poor	Shyness, timidity.
3	B	6 — 0	2 years retarded	Italian	40–45	0	0	Fair	Nervous, over-active.
4	B	5 — 6	1 year + retarded	Italian	25–30	0	3	Good	Shyness, timidity.
5	B	5 — 10	1 year retarded	Italian-American	35–40	4	2	Poor	Stubbornness, sulking.
6	B	4 — 5	1 year retarded	Italian	45–50	5	0	Very good	Possibly defective; faulty articulation.
7	G	5 — 6	Sub-average	Italian	25–30	1	3	Fair	Shyness, timidity; difficulty with tools.
8	B	5 — 11	1 year retarded	Italian		2	0	Very poor	Shyness, timidity.
9	B	5 — 10	Low average	Italian	30–35	1	0	Fair	Delicate, unhappy.
10	B	7 — 0	Mentally defective	Italian	25–30	2	0	Fair	Fighting.
11	B	4 — 9	Sub-average	American	20–25	1	0	Fair	Possibly defective; faulty articulation.
12	B	4 — 10	1 year + retarded	Italian	30–35	1	0	Fair	Shyness, timidity.
13	G	5 — 10	Low average	Italian	30–35	1	3	Fair	Habit spasms.
14	B	6 — 0	2 years retarded	Italian	35–40	1	2	Poor	Shyness, timidity.
15	B	5 — 10	2 years retarded	Italian	40–45	4	1	Fair	Fears, shyness, timidity.
16	G	5 — 8	1 year retarded	Italian	40–45	3	0	Poor	Shyness, timidity.
17	G	5 — 4	Low average	Italian	35–40	4	2	Fair	Nervous; uncontrolled.
18	B	5 — 5	Low average	Italian	30–35	0	1	Fair	Temper.
19	B	5 — 9	Sub-average	Italian	25–30	0	1	Good	Faulty articulation.
20	G	5 — 5	Average	Russian Jew	40–45	3	0	Very good	Baby talk; incessant talking.
21	B	5 — 4	Average	Italian	30–35	1	1	Fair	Incessant talking.
22	G	4 — 2	Average	Italian	45–50	6	1	Very poor	Shyness, timidity.
23	G	5 — 10	Average	Italian	40–45	4	1	Very poor	Demands attention.
24	B	5 — 7	Average	Italian	40–45	4	0	Fair	Shy, reserved.
25	G	5 — 11	Average	Italian-American	30–35	2	1	Good	Superior; slight habit spasms; shyness.
	17 boys 8 girls								

of the twenty-five children are shy, timorous, and lacking in healthy self-confidence. The regular work of the kindergarten exercises a very fortunate and beneficial influence on many of these children; but there remain a few children who, because of impaired personality make-up or subnormal intelligence, are peculiarly in need of special guidance at the kindergarten ages. Such children remain unadapted to the group even after months of attendance. Frequently they are maladjusted or fail of promotion in the first grade. The maladjustment tends to increase in gravity if not dealt with early, and there is an accumulating waste of effort on the part of the teachers as the child grows older. It is certain that a considerable amount of preventive and ameliorative work can be accomplished by beginning early and meeting these problems before the child reaches the primary school.

Each individual case study made by Miss Washburn was summarized in an educational analysis to determine the kind and degree of special guidance needed. For illustration, three of these summaries are reproduced below. The educational status and recommendations are itemized in parallel columns. The first column describes the special-guidance problem, the second the desirable special-guidance procedure. The figures in parentheses correspond to the items in the first column.

11. BOY, AGE 4 YEARS, 9 MONTHS

Special-guidance Problem	*Special-guidance Procedure*
Capacity of child	a. *Contact with kindergarten group*
1. Consistent four-year development. Child 4 years, 9 months.	(1) Remove from group except during song-and-game period.
2. Very definite speech difficulty.	b. *Special training by other children*
Personality traits	(2) Grade VIII child to give child practice in the correct pronouncing of words (under direction of special-guidance teacher, with due attention to patience and accuracy of instruction).
3. Amenable, good tempered.	
4. Immature for age.	
5. Lacks initiative and imagination.	
6. Fairly self-confident and poised.	
Home and social factors	c. *Social work*
7. American mother very young and children's lives are suited to her convenience.	(7, 9) V.N.A. to visit home and help mother to regulate children's diet and hours. Special-guidance teacher to arrange with neighbor to care for children, so they need not be taken out at night. Persuade mother to let child play outside with other children, even though yard is small.
8. Home opportunities for development meager. Play restricted.	
9. Underweight.	

d. *Work with special-guidance teacher*
(1) Handwork suited to 4-year development.
(2, 8) Responsibility developed by means of tasks in care of schoolroom or other children.
(5) Special opportunity for constructive group play.
(7) All work calculated to supplement faulty home aids to development.

12. BOY, AGE 4 YEARS, 10 MONTHS

Special-guidance Problem

Capacity of child
1. Retarded development; not equal to regular kindergarten work.
2. Conversation limited.

Personality traits
3. Lacks self-confidence to an unusual degree.
Needs approval.
Is convinced of inability to perform tasks set.
4. Immature.
Indulged at home.
5. Sociability with other children undeveloped, though kindergarten great help.

Home and social factors
6. Practical isolation with Italian-speaking mother.
One other child in family, 4 years older.
Very little contact with children outside.
7. Experience largely with foreign language.
8. Entrance into kindergarten accompanied not only by terrors of meeting a group of children, but also by inability to perform tasks which repeaters in the group performed with great readiness. Consequent discouragement over failure.

Special-guidance Procedure

a. *Contact with kindergarten group*
(8) Withdraw child from kindergarten except during time when whole group learns new songs, hears stories, etc.

b. *Special training by other children*
(2, 7) Training in naming objects (in room and in pictures) and general conversational practice with older child (supervised by special-guidance teacher).

c. *Social work*
(6) Home visits by special-guidance teacher to impress upon mother necessity for boy to lead somewhat more independent life with contemporaries, and
(4) development of responsibility by means of light tasks at home.

d. *Work with special-guidance teacher*
(1) Handwork well within boy's capacity in order that (3) self-confidence may be established by success.
(4) Tasks in schoolroom or building set to develop responsibility.
(5) Special opportunity for constructive group play with very little or no supervision.

9. BOY, AGE 5 YEARS, 10 MONTHS

Special-guidance Problem

Capacity of child
1. Low average intelligence.
2. Good conversational ability.

Personality traits
3. Sociable and fairly self-reliant.
4. Somewhat morbid.
5. Desires leadership, but is incapable of attaining it.
5a. Boy very fearful and timorous.

Home and social factors
6. Mother and father separated. Father trying to influence boy to leave mother.

Special-guidance Procedure

a. *Contact with kindergarten group*
(1) Remain with regular kindergarten group.

b. *Special training by other children*
(10, 4, 5) Outdoor play with group of other children; arranging opportunity for boy to lead in games and prove his ability to do so.

c. *Social work*
(9) Regulation of boy's diet and daily régime by V.N.A.

7. Father influenced boy's initial attitude toward school and boy always expresses unwillingness to go to school.
8. Mother finds life difficult, and her attitude of depression is undoubtedly transferred to the boy.
9. Boy's delicacy and mother's personality have resulted in faulty home training.
10. Play opportunities in neighborhood are very limited.

(6, 8) Stabilization of family situation by Organized Charities, with possible coöperation with Mental Hygiene Society in regard to mother's attitude of depression.

d. *Work with special-guidance teacher* (4, 5a, 7) Problem is largely one of faulty mental hygiene in this case. Special emphasis should be laid on overcoming boy's morbidity, general attitude toward school, special fears, etc.

Individual case studies such as the above suggest concretely how special-guidance procedure may be put into operation through the kindergarten.

SPECIAL-GUIDANCE MEASURES

It is possible to institute special individualized programs for exceptional children within the regular kindergarten room. The very flexibility of the kindergarten makes it possible. With only minor modifications of equipment and procedure, it is feasible to study the needs of certain exceptional cases and to provide these needs in an ordinary kindergarten. Although the regular kindergarten teacher cannot be expected to give a disproportionate amount of attention to any problem child, she can carry such a child more intelligently and comfortably in the regular group if she makes special provision for him. These special provisions might be worked out in conference with the supervisor of special classes and with others who have made a special study of any selected case.

In school systems of some size, this individual program work can be best developed by the appointment of a special-guidance kindergartner. Such a special kindergartner could be attached to a regular kindergarten. She might be given major charge of about ten exceptional children recruited from one district and from neighboring kindergartens. It would not be necessary to conduct this special work altogether apart from the regular group. Indeed, there would be some advantages in conducting it in relation to the regular work. This would be a conservative method of demonstrating the possibility of instituting special mental-hygiene procedures for special kindergarten children in close relation to the ordinary kindergarten work.

Problem children such as have been investigated in the New Haven study are in need of varying degrees of special educational guidance. Some need a great deal of it; others need only minor adjustments and occasional timely assistance, which only a special-guidance teacher could render. Still others would be benefited by home visits on the part of the teacher.

It is suggested that a special-guidance kindergartner might spend about half of the day in systematic work with a small group of problem children and that she could devote the remainder of her time to instituting similar special individual programs for children in other kindergartens—that is, out lining and supervising these programs and giving special assistance to the regular kindergarten teachers and parents concerned. It is conceivable that by such individualized methods such a teacher might set into operation as many as twenty more or less specialized programs for exceptional children. This arrangement would entail no unusual expenditure for equipment or rooms or materials and would furnish a solid basis for an intelligent expansion of the work. Incidentally, it would also demonstrate, not only the value and economy of special-guidance work in kindergartens, but of similar work for children of elementary-school age who cannot be assigned to special classes.

The kindergarten has an opportunity and still more a responsibility in meeting the educational and hygienic needs of its exceptional children. The handicapped child of kindergarten and of pre-kindergarten age is peculiarly neglected both at home and at school. To our knowledge, no kindergarten has undertaken systematic work in this field. Clinical work with young children and the nursery-school movement have indicated the importance of this unsolved problem. The best solution is not the creation of an additional and lower tier of special classes; but the development of a more flexible, individualized kind of special-guidance service, directed to both the child and the home. The kindergartner holds a key position in the field of child hygiene. Revisions in technique and professional training will enable the kindergarten to prove its great importance as a public mental-hygiene agency.

ENURESIS AS A PSYCHOLOGICAL PROBLEM

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NO ONE has ever determined, statistically, the prevalence of enuresis among young children, but every pediatrician and every clinical psychologist knows how widespread the difficulty is. Many mothers hesitate to seek advice about it because they are so thoroughly ashamed of it. Yet the problem is one that particularly needs illumination because it is the source of so much hidden conflict and unhappiness for parent and child. Perhaps none of the common difficulties with children cause more irritation in the household and more nervous and emotional upsets than this. Bed-wetting is a habit productive of so much discomfort to the entire family and so much extra labor that few mothers can accept it with any equanimity.

In considering the possible cause of enuresis in any child the first point to determine is whether or not there is any physical cause for the difficulty. A physician should be called in to give a complete and thorough physical examination. Often a series of laboratory tests is necessary before it can be determined whether or not a physical basis is present. If physical difficulties are present, the first step is obviously their treatment and cure. But most authorities agree that a large majority of cases reveal no physical cause for the trouble; many physicians put the proportion in which no physical cause is detectable as high as 90 per cent. The possibility, however, that physical difficulties, though as yet undiscovered, are playing a part in the result should always make one particularly gentle and careful in dealing with children suffering from this defect. Some recent studies suggest that endocrine disturbances, which are as yet little understood, are a contributing cause.

Many pediatricians feel quite hopeless about cases of enuresis in which no physical difficulties are discoverable. They say quite frankly that they have found no successful

way of dealing with such cases and they frequently advise parents simply to wait for adolescence, when the trouble usually disappears.

In so far as enuresis has no physical cause, it must, of course, be regarded as primarily a problem of habit training and of the mental attitude of the child. One can scarcely begin to discuss what goes wrong in a field of training until one has stated what seems to be the normal course. No adequate studies have as yet been made of the process in young children of learning control of urination. It is a fruitful field for investigation which scientific mothers will doubtless soon enter. Statements made about it in this paper have no standing as scientific fact; they are based merely upon the judgment of one observer who has had personal experience and who has conferred with many mothers of normal children about the age at which training for the toilet was undertaken and the methods that proved successful.

There is a wide difference of opinion among mothers of various races and social levels as to the proper age at which a child should be expected to learn to control the process of elimination. Some mothers believe that the greater part of the training should be accomplished under one year, while others think that two years is too young to expect reliability. The following statements about the matter are based upon the experiences of American mothers of good social status. By the time a baby is a year old, he should be thoroughly familiar with the use of the chair for elimination. Most mothers begin under six months to use the chair for bowel movements, and by the time a child is a year old he should also have the idea of using it for urination. At one year, then, a child should be using the chair for bowel movements with a good degree of reliability and should have at least the concept of using it for urination. By eighteen months a normal child should be wearing panties and should be fairly reliable in the daytime. By two years he should be well trained for the daytime, with accidents rare, and should be beginning to have dry nights. By two and a half or three years, he should be reliable at night and able to waken himself for necessary uses of the toilet.

There are undoubtedly wide variations even among normal

children. It is not uncommon to have children of eighteen months dry at night. Occasionally in this country and more frequently in England children are reliably trained at from twelve to fourteen months. On the other hand, there are normal children who are as old as two years or even a bit older by the time they are trained for the daytime. The age at which one begins to call bed-wetting enuresis depends upon one's conception of the age at which training should be complete. In general, a mother should seek help if her child is still unreliable in the daytime at two and a half or unreliable at night at three years. The child's individual history with regard to health and amount of training should be taken into consideration.

In discussing methods of training young children for the toilet, one is tempted to begin by a prohibition. *Never use severe punishment in securing the proper use of the toilet, and never arouse fear in connection with the use of the toilet.* The most successful method is undoubtedly that which consists of making a business of forestalling the child and keeping him dry by taking him frequently to the toilet. When in the mother's judgment the child is old enough to learn, she ought to make up her mind to devote herself to this problem for a few weeks, perhaps for a month or two. She should find out what the natural rhythm of urination is, and then take the child to the toilet often enough so that he is kept dry most of the time. For most children this process should take place somewhere between twelve and eighteen months; fifteen months is a very usual time to begin it. In getting the child trained, the stress should always be put upon pleasure in success and never upon disapproval for failure. If some disapproval is necessary, it should certainly not be of the repressive or fear-producing variety. The child should learn to take satisfaction in being able to use the toilet properly.

As soon as the rhythm and habit of using the toilet are fairly well established, the mother should begin to put the responsibility up to the child. He should be taught to tell when he needs the toilet and to feel that it is his task and not his mother's to keep himself dry. As I shall attempt to point out later, success or failure is very intimately bound

up with the kind of attitude the child himself establishes in his own mind toward this whole process of the use of the toilet.

As soon as the child has the idea and the habit pretty well established in the daytime, the training at night should be begun. It is wise to restrict liquids moderately toward bedtime when the child is first learning to have dry nights. He should also be taken up and put on the toilet after a few hours in bed. For most children, nine to ten o'clock is a good time. The wise thing to do is to find out about when urination is apt to occur for the first time after the child is put to bed, and to take the child up in time to forestall that. In the morning the child should be placed on the toilet as soon as he wakens. The mother must begin arousing an ambition to have a dry bed, and express approval and appreciation when this is successfully accomplished. The child should acquire early the idea that it is entirely possible for him to waken himself if he needs to go to the toilet. By the time a child is four years old, or before, he should be able to waken himself and attend to his own needs without disturbing any adult. To secure this result it is often wise to place a little chamber by the child's bed so that he can get up and use it easily without the need for going to another room or having a light.

The most common failures in developing correct habits about the use of the toilet have to do with the age at which training is undertaken, and with the emotional atmosphere that surrounds the training. They might be listed as follows: first, postponing the period of training beyond the natural time for it; second, conducting the training in such a spirit that the child's antagonism is aroused and he comes to desire to wet his clothes or his bed to annoy the adults and get his own way; third, making the bad habit the occasion for emotional scenes of an exciting kind, in which case the child may keep it up just for the satisfaction of being the center of the stage and the object of so much emotional solicitude; fourth, using such severe methods of training and surrounding the child with an atmosphere so repressive and unhopeful that he develops a fear of wetting which is in itself enough to make him do it. He gets obsessed by the idea of doing it instead of being filled with a faith that he can keep from

doing it. A child who is anxious to please, and at the same time afraid that he cannot, is apt to be betrayed into this type of obsession. Fifth, there is the failure resulting from undue emotional dependence upon the mother; a vague desire to continue the period of infancy and enjoy the kind of maternal care given to infants may be the determining cause. No case is simple enough to display only one of the situations suggested above, but in most instances one or another of them seems to be outstanding. They will be discussed in turn.

First, postponing the period of training beyond the normal age. When, because of some emergency, it has not been possible to train the child at the usual time and he is allowed to go without any effective training until he is two years or more of age, it becomes much more difficult to train him at all. The problem is one that is frequently met in institutions for neglected and dependent children. It is not easy to be sure of the reason why a belated training is so much more difficult than one undertaken at the proper time. For one thing, the longer a child is allowed to go untrained, the more firmly the habit of urination in response to desire and without regard to circumstances becomes established. It is a question then of breaking up a bad habit as well as of substituting a good one. In addition to this, the child whose training is begun as late as two years of age or more has already reached a stage of greater independence of personality and of fondness for negative reaction. He is apt to resent and to resist training as a younger baby does not.

Second, the establishment of negative reaction. Negativism constitutes a very frequent stage of development in very young children. It seems to be a natural step in the development of personality. When a child begins to get a feeling of himself as an independent agency, he enjoys trying out his powers. Many mothers feel that this stage is a budding insurrection against authority which must be downed. Since training for the toilet constitutes a necessary field of discipline at this age, it is not surprising that the battle often takes place on this ground. Once a child becomes determined to oppose his mother by wetting himself, he is certain to be able to win out. An independent, strong-willed child may become so absorbed in the battle that it is extremely difficult to stop it.

Either he must be fought to a finish—and probably injured in the process—or his attitude must be peaceably changed from one of determination to wet himself to one of determination not to do so. An attempt to dominate unduly and unreasonableness and inconsistency of management are the parental attitudes most apt to call forth this pathologically negative reaction.

The point can be illustrated by the behavior of little Margaret, whose mother brought her to the Consultation Center very largely because she was still wetting her clothes in the daytime, wetting her bed during her nap, and wetting her bed at night, when she was almost four years old. Margaret was the child of rather nervous, high-strung parents. Her father had been a victim of "shell shock" during the World War and was far from recovered from it at the time of her birth. Her mother was an intense, high-strung little person, none too strong physically, who found it very hard to meet all the obligations of life. A younger child had arrived in the family at about the time Margaret should have been trained for the toilet. The mother felt physically unable to cope with the situation adequately at the time. She was impatient and inconsistent in her methods, and she attempted to make up by spasmodic severity what she lacked in systematic training. The effect was to arouse Margaret's antagonism. The child was one of the most negative that I have ever seen. One could be perfectly confident that any suggestion would be met with a negation. The satisfaction she got from thwarting her mother about the bed-wetting and her joy in the rows that resulted from it were one of the chief interests of her life. Her superior intelligence (her quotient was 133) made her no mean antagonist.

Margaret was accepted temporarily for observation in the nursery school. The first day she arrived accompanied by a bag containing a rubber blanket, a bed pad, and a change of clothing. After consultation with Miss Henton, the headmistress of the nursery school, we decided to ignore this paraphernalia and say nothing whatever to Margaret about her bed-wetting proclivity. So far as she knew, no one in the school was aware of it. She loved the school from the first moment, and spent the morning intently watching the children

and joining in their projects whenever she could. When it was time for Margaret to go up for her nap after lunch, she trotted up with the other children, keeping an eye out watchfully to see what they did. She was shown where her cot was, and promptly sat down upon it and began to take off her shoes as the other children did. When the others lay down to go to sleep, Margaret did the same. She went to sleep on the very first day and woke up, to our joy, perfectly dry. It was the first dry nap she had ever had. Occasionally, by taking her up two or three times, her mother had gotten her through a dry night, but never once had she had a dry nap. Not a word was said to her on the subject. She was simply taken for granted as a satisfactory member of the school.

She was in the school for three weeks and never once during that time did she wet her cot during nap time. However, during the same period, when she had her nap at home on Saturdays and Sundays, she reverted to her old habit. It seemed to us a complete demonstration that the cause of the enuresis was certainly to be found in the child's attitude toward the whole problem. At school she wished to do as the others did and to be approved of; at home she wished to thwart her mother and have exciting and interesting rows with her. She was later taken for several weeks by a member of the staff, and reached the point where she could be reliably dry in the daytime and have a series of dry nights, eight or nine in succession. She has not yet succeeded in eliminating the bed-wetting completely. As soon as she went home and returned to her mother's management and the home atmosphere, she relapsed somewhat, though not to her old level. We did our best to explain to the mother the source of the trouble, and to help her change her method, but the difficulty of transforming the atmosphere of a home and changing the emotional set between mother and child is great.

Little John, a child of average intelligence (quotient 106), who came to the Consultation Center at four, illustrated the same problem, though in a less severe form. John was a child who had been betrayed into an attitude of conflict with his slightly neurotic mother. He was a somewhat unwelcome second child. The mother's *rapport* was with the older brother

who presented no problem. John was himself a healthy, wholesome youngster, much less excitable and nervous than Margaret, though displaying excessive negativism. This was shown by the fact that he would often cry and object and refuse to use the toilet when placed on it, but wet his clothes immediately afterward.

John was exceedingly anxious to have a little baby sister and frequently begged for one. One day when he was pleading for the baby sister, his older brother, aged seven, said to him:

"Why, John, mother can't have another baby. You're baby enough. You wet the bed every night, wet your clothes in the daytime, and behave like a baby, and make her so much work that she couldn't possibly have another baby on hand to take care of."

John saw the reasonableness of this, and it evidently made a very deep impression upon him. Although up to that time he had wet his clothes every day and systematically wet his bed at night, he suddenly became completely dry for two whole days. He not only went to the toilet himself in the daytime when he needed to, but he woke himself up at night. By the end of the two days, however, with the prospect of a little sister no brighter than it had been before, he probably decided that the remote hope of the baby sister was not worth the effort. At any rate, he relapsed into his old habits.

John's case proved to be an easier one to conquer than Margaret's. One difficulty was that he had been allowed to stay in bed for thirteen hours without getting up at all. The reason was that he was so cross when he was wakened at night that his parents gave it up. As soon as they understood the necessity for it, they wakened him systematically, regardless of his resentment. After four nights of crying and stubbornly refusing to use the toilet when wakened, he gave in and did it peaceably. In a few weeks' time the chief problem was conquered; calm and systematic insistence upon the use of the toilet at suitable times, and making him repair the damage as far as possible when he transgressed, solved the problem.

Third, the love of emotional scenes. If the method of training adopted results, not in a battle, but in a highly emotional

scene, the child may develop a love for the emotional excitement. Every child likes to be the center of interest. A child who causes great concern to the adults about him often gets a very real satisfaction from the degree of excitement he can create. He has a pride in his bed-wetting as the aspect of existence which gives him most limelight and the greatest sense of importance. Various other things beside bed-wetting may play the same rôle. For one child persistent refusal to eat, for another biting her hand, for another sucking his thumb were the habits that stirred such a gratifying degree of concern in adults. In several instances the presence of a preferred brother or sister, who normally received most attention in the family circle, increased the child's desire to make himself felt. Both Margaret and John were children who enjoyed the emotional scene, as well as the row. John, in addition, had to contend with a preferred older brother.

One seven-year-old child was apparently keeping up the habit of bed-wetting because her father, who took her up at night, made the occasion one for a great deal of petting—a kind of nocturnal love feast. If her bed-wetting were entirely given up, there would be no further occasion for these gratifying scenes with her father.

Fourth, fear. If the methods used in training for the toilet are repressive, and the child is sensitive, he may develop a fear of not being able to control himself which is sufficient to prevent the control. Intense social disapproval is an even more common source of this type of fear than severe physical punishment. The child desires to please and win approval, but becomes so convinced that he will be unable to do it that the fear itself brings about the bad results. Instead of becoming sure that he can control himself, he becomes sure that he cannot, and that in itself is sufficient to destroy the possibility of control. Such a child often develops a chronic anxiety state which approaches an obsession. The presence of a solicitous mother, who also dreads the habit and who keeps reminding the child of it constantly in the hope of forestalling the trouble, serves to aggravate the condition. Very frequently an inferiority feeling which is a serious detriment to a child's personality develops.

One little girl of ten years was brought to us for help in

such a situation. It took about a year to help this child and her mother to change their emotional set. The mother was persuaded to cease her constant reminders and to assume a more hopeful attitude. The child was led to believe that she could conquer the habit and to assume the responsibility for it herself. She reported directly to the psychologist and avoided discussions with her mother. An illness of the mother, which created an urgent reason for the child to assume responsibility, not only for herself, but to some extent for her mother, helped to effect a cure. In some aspects, this case belongs under the next type, that of infantile dependence on the mother, but the child's anxiety state was so marked, her desire to control herself so keen, and the beginnings of a hampering sense of inferiority so clear in her social behavior, that the case seems best classified under fear.

If fear is the chief determining factor, then obviously the removal of the fear-producing discipline, and the substitution for it of self-confidence and joy in success and the sense of mastery is the correct method.

Fifth, infantile dependence on the mother. There are cases of enuresis in which the desire to remain dependent on the mother seems to be the source of the trouble. If the mother is conscientious, solicitous, and very affectionate, and if in addition she intensely enjoys caring for the child, she may make the situation of being a baby so satisfying that the child is loath to give it up. He begins to practice his wiles to preserve for himself his sense of being constantly looked out for, surrounded with loving care, and protected from any sense of responsibility. He does not wish to be thrust out to look after himself. The attempt to train a child for the toilet constitutes a necessary step in producing independence and bringing an end to the infantile type of care; hence it is a probable background for this emotional set.

We had under observation for nine months a little girl of four who illustrated this situation. The mother was an intelligent, conscientious woman who had been through some very trying experiences in life, and had lost one older child. She was so absorbed in this child that she supervised her every breath. Toilet training was begun at a year, an age so young that the only permissible method was that of trying to forestall

the child and making the successful use of the toilet an occasion for rejoicing. Nevertheless, at the advice of a pediatrician, the mother began spanking the baby for transgressions. The doctor's idea seemed to be that a little sharp punishment at the start would end the difficulty. Though it wrung her heart, this conscientious mother carried out instructions. How much this infantile experience had to do with the outcome, it is difficult to say. At any rate, though Amelia was much above average in intelligence (her quotient was 134), and no physical difficulties could be discovered, it proved impossible to train her for dry nights. Her mother continued her enveloping and affectionate care of the child. She was omnipresent in the child's life, not out of a desire to dominate, but out of excessive affection and conscientiousness. Whenever the matter of the toilet and her bed-wetting was the subject of discussion, a peculiar expression of reserve and resentment and secret purposes of her own came over Amelia's face. She never would discuss the matter. The mother could not interpret her attitude, and felt baffled and worried by it. She continued her battle to secure dry nights by restricting liquids toward bedtime and by taking the child up at night, but her efforts called forth no coöperation from the child. It was not that she fought her mother, but that she refused to play any but a purely passive part. When taken up at night, she behaved exactly like a baby. She cried like a baby, was carried to the toilet and back again, was laid on another bed while hers was changed, if necessary, and then carried back to her own bed.

The cure in this case centered about depriving the child of the satisfaction of being treated like a baby and making her take the responsibility for her behavior herself. At night her mother wakened her, but then insisted that she get up, put on her bathrobe and slippers, and take herself to the toilet. If her bed were wet, she was the person to change it. Her mother lay unconcerned in her own bed while Amelia did what was necessary, put out the light herself, and got back to bed. In the morning there were sheets and nightdress to be washed by Amelia, and disconcerting indifference on mother's part to any aspect of the situation except getting the necessary work done. A record of dry nights was kept,

and great was the rejoicing when the series was long. When the inevitable relapses came, they were accepted with equanimity and a new start made.

It took nine months to remake the attitude of mother and child. During this period there were various occasions on which the value that Amelia attached to wetting beds and panties came out. One day, in playing with some "hard-boiled" little boys who refused to comply with her demands, she was heard to remark, "If you don't, I will wet my panties." They looked at her in scornful surprise and said, "Go ahead and wet your panties. We don't care." When she was finally convinced that her weapon was worthless, either at home or abroad, she gave it up.

There is one circumstance about the genesis of enuresis that calls for comment. In many cases, the mother reports a period of apparently successful training, after which the child relapses into bed-wetting, and cannot be cured. The period of relapse is usually marked by some illness, or some radical change in mode of living. It is, for instance, well known to nursery-school teachers that two-year-old children who enter with a report that they are trained at home frequently relapse into wetting their clothes on entering the school. The change of environment tends to upset so newly acquired a habit. A little patience and a short period of reëducation reëstablish the habit and make it valid for school as well as for home.

When such relapses occur at home, and the mother fails to understand the reason for them, she is apt to resort to severe discipline or to emotional scenes. Having once trained the child with all due patience, and made sure that control is possible to him, she finds it impossible to endure his backsliding with equanimity. Unwittingly she puts on the kind of pressure that arouses antagonism, fear, or fascination with emotional scene, and thus establishes the habit of enuresis.

No discussion of enuresis would be complete without calling attention to the fact that it may be related to masturbation. In how large a proportion of cases this is true no one can say at present. Masturbation probably serves in several ways to increase the difficulty of dealing with enuresis. It tends to increase the sensitiveness of the genital regions, to decrease

the child's degree of control, and to arouse a desire for stimulation which leads to more frequent urination. The act of voiding urine may come to have a primitive sexual value of its own. One little girl of eight, who was a persistent, determined, and totally unrepentant bed-wetter, announced that the reason she did it was because it gave her pleasure to do it. When complicated with masturbation, the habit is even more difficult to break up. In addition to being associated with emotional attitudes that help to maintain the practice, it has value as a source of immediate physical pleasure. The possibility of a complication with masturbation is a matter to be kept constantly in mind in dealing with persistent and difficult cases of enuresis.

It is possible that even when not complicated with masturbation, enuresis may tend to persist because of its connection with rudimentary feelings of sex.

Suggestions for treatment if no physical cause is present. First, let me state the changes a parent most frequently needs to make:

Stop all punishments.

Stop all arguing and rowing.

Stop all displays of intense emotional concern and substitute for them a matter-of-fact attitude.

Cultivate an optimistic spirit.

Second, let me state the changes that should be induced in the attitude of the child:

Eliminate fear.

Build a faith that success can be attained.

Stimulate interest in success.

Develop a sense of responsibility on the part of the child for his own behavior.

The best method of developing a belief in the child that he can succeed is for the adult to cultivate in himself an atmosphere of optimism and confidence. Very frequently some outside source of stimulation and inspiration is necessary. The doctor or the psychologist may be able to build up the faith of both parent and child. Frequent reassurance and suggestions of success help. Getting the child to adopt the idea that he can learn to waken himself at night when he needs the toilet is a long step toward success. Some doctors

have even gone the length of pretending to perform an operation, with assurances to the child that the operation would bring about a cure. Even though it may have succeeded in certain instances, the method is not one that can be recommended. A general anæsthetic is too dangerous to be employed unnecessarily. Furthermore, a cure built upon a fundamental falsehood is a house built upon the sand. There are too many chances that the child will discover the truth and feel that he has been duped. Complete honesty of attitude should be the foundation of mental hygiene for young children.

Interest in success and a desire to attain it may be promoted in many ways. Here, again, a completely candid attitude on the part of the adult is essential. Some doctors have adopted the plan of administering a bad tasting, but harmless medicine to the child every time he was discovered wet, with the assurance that the medicine would cure the wetting. Margaret's mother tried the plan on her at one stage, but Margaret was too keen to be taken in. She understood the entire transaction, and retaliated by wetting both her clothes and her bed more persistently than ever until the medicine was discontinued. She proved to her mother that the medicine would not work. More legitimate methods of arousing interest are to be found. Strong social approval for success is one of the best. With children old enough to understand it, a visible record of success, in terms of a calendar marked with a star for every dry night, often helps. A record should be kept to show to some outside authority, such as the doctor, psychologist, or social worker, and should be submitted at regular intervals—once a week for children from three to six and as often at the start for older children, though it is often possible to lengthen the interval for them later. In keeping a calendar, the best policy is to mark successful days only and leave the unsuccessful days blank. In one instance, a five-year-old was asked to mark her successes with gold stars and her failures with blue. The sight of a series of blue stars proved so discouraging that she laughed the whole record to scorn and remarked that she didn't care how many blue stars there were. Her mother finally offered to allow her to cover up some of her blue stars with gold ones if she had particularly successful days, with the understanding that the psychologist

was to be told about the transaction. Her interest was thus revived, and she went on with the schedule. Since then no request for marking failures has issued from that office.

Often a new social situation furnishes a most vital kind of interest and motive for controlling enuresis. Margaret, when she entered the nursery school, had an entirely adequate motive to enable her completely to control the enuresis during nap time. Not a word had been said; it was merely the situation in the nursery school that accomplished the result. Frequently children suffering from enuresis are free from it when going on a journey. The desire not to become conspicuous in the train seems to be sufficient to lead to self-control. Going away to school will often accomplish the same result. The desire to stand well with one's fellows constitutes a sufficiently strong motive.

Fully as important as developing a strong interest and motive is the development of a sense of responsibility on the part of the child. It is absolutely essential that the child be made to feel that attending to his own toilet needs is distinctly his job and that he cannot depend upon any outsider to do it for him. In the original training, teaching the child to attend to himself at the toilet as early as possible and to tell when he needs the toilet as soon as he has really gained command of the process are the essential factors.

If enuresis has once set in there are certain measures that frequently help in bringing about a cure. The child must, of course, be taught to waken himself at night. Very many children are unable to sleep through the entire night without urination, but if they are able to waken themselves there is no difficulty. The child who has enuresis is not able to do this and must be taught to accomplish the result. Frequently children suffering from enuresis seem to sleep very soundly and prove to be difficult to waken. When taken up in the night, the child should be thoroughly wakened and made to attend to his own toilet needs. He should put on his own bathrobe and slippers, go to the toilet himself, and do everything possible about it. He should even be required to do as much of the waking of himself as possible. A child should not be shaken and picked up; he should be touched and spoken to a number of times and taught to waken first at a

touch or at the sound of the voice. The less the stimulus required for waking, the more probable it is that the child can waken himself without any stimulus at all. When wakened, he must be led to feel that the adult is doing it merely to help to teach him to waken himself and does not expect to keep that responsibility permanently.

Finally, the child who wets his clothes or his bed should be made to take the responsibility of changing the bed or the clothes, and of washing his clothes and his sheets. Even four-year-olds can do this with a little supervision. The requirement should be made not in the least in the spirit of punishment, but merely as the natural consequence of the child's act. If by his wetting of clothes and bed he makes as much work as that, he should be required to do all of the work possible himself. No emotional upsets should accompany this demand; it should be presented merely as a matter of social justice. In many instances the child whose sense of responsibility about bed-wetting must be aroused is also in need of it in other directions. This will constitute only one instance of the development of responsibility and the same principles should be applied elsewhere. Such a child should be taught to dress and undress himself, to feed himself, to put away his toys—in short, to play his part as an independent member of the family and community in so far as he is able.

"WHAT CAN I DO WITH JOHNNY?"

THE NEED FOR MORE ADEQUATE PROVISION FOR THE CARE OF THE PSYCHOPATHIC CHILD

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"WHAT can I do with Johnny? He isn't just bad. I think he's a little off. He isn't dumb. You should see his marks in school. But the teachers—they just can't stand him, and I'm wore out! I can't do a thing with him and I'm afraid he'll kill the baby. Where can I put him?"

How many social workers, doctors, nurses, teachers, and even ministers and priests have heard that appeal a hundred times over, with only minor variations, from hundreds of frantic parents, and how many can offer a solution?

Johnny represents an ever-increasing problem to parents, teachers, and social agencies. In the terminology of psychiatry, he frequently appears labeled "psychopathic personality", indicating an emotional instability in the formative period of childhood; or perhaps "border-line case", meaning a case that falls just short of being a frank psychosis; or case of "post-encephalitis", a term embracing all manner of abnormal mental manifestations in the emotional and volitional spheres as well as practically the whole gamut of organic nervous disorder following a history of encephalitis lethargica.

Johnny has a record of tantrums, malicious behavior, stealing without intent, pinching, striking, and spitting at other children, vagrancy, incendiarism, or sex perversion. One or all of these may be safely laid at his door. Punish him we cannot, for his glib tongue and over-active brain run on, about, and through all our punishments with a disconcerting indifference; yet we must curb him, for well we know that he has before him either prolonged or permanent incarceration within the walls of a hospital for the insane, or the vicious cycle of correctional institutions, from juvenile protectory to state's prison. However, in his present condition, he represents

neither the criminal nor the psychotic, nor can he successfully be treated as such. Therefore, let us take stock of our present facilities to see how much each can contribute to his care.

First, we have his natural environment—the home. I can state, from my own knowledge of six hundred case records in a social agency dealing with behavior problems in children, that the homes from which such children come fall roughly into three groups: the over-indulgent, the callously indifferent, and the over-disciplinary. I make this classification on the basis of attitude rather than economic or cultural status, for the question of adjustment of the psychopathic child is chiefly one of attitude toward him. Not one of these three types of homes is equipped to handle Johnny. The over-indulgent follows his every irrational whim with a loving protection that irritates the child and turns the attendant family into a group of neurotic, over-strained individuals, incapable of seeing beyond their present problem; the callously indifferent thrust their child upon the shoulders of the community to deal with as it can; and the stern disciplinarian beats and punishes his child until he breaks what little mental resistance is left and sends a deteriorated mentality for an indefinite time to a mental hospital, or thrusts into the world an irrational, embittered adolescent, ready, with his apparent "brightness", to pick our pockets, rob our houses, hold up our cars on lonely roads, and even murder us! I do not say that there is not an occasional home with the understanding and intelligence to care for an abnormal child had it the proper equipment, but I do say that in the course of several years' experience with social work among problem children I have never found one home that offered adequate opportunities for adjustment for a psychopathic child.

If the home cannot adequately protect the a-social child, the second logical suggestion that offers itself is the school, and here we find a problem worthy of a thesis in itself. What has our present school system to offer in the way of care for border-line cases? One might answer, "Special classes", forgetting that these classes have been devised to meet the needs of a child with low-normal or defective intelligence. I have on my records at the present time at least six specific cases that have been excluded from the New York public

schools at the recommendation of the Department of Special Classes because the school could not deal with their problems. These children had too high an order of intelligence to be placed in an ungraded class and too high a degree of emotional instability to adjust in a class of children of normal intelligence. In each of these cases I made a personal contact with the superintendent and teacher of the school that the child attended, and in each case the request to the agency was the same: "Have you any place to put this child? We cannot keep him in school—he assimilates nothing and is a menace to the other children."

This statement from the school leads us to our third consideration with reference to the border-line child—the problem of his juvenile associates. If school and home could devise methods to keep him stabilized and interested and train him to orderly habits, what of the large body of children with whom he comes in contact? Again, to quote our agency records, we have case after case in which, for example, B., aged twelve, attempted sexual intercourse with his sister, aged seven; or C., aged fourteen, was the victim of at least twenty adults in homosexual experiences; or D., aged eleven, tried to strangle his baby brother; or E., aged fifteen, led a docile child of twelve as his hobo companion the length of the state and then abandoned him to the police. B., C., D., and E. are labeled on our records psychopathic personality, emotional instability, border-line mental defective, post-encephalitis, or constitutional psychopathic inferiority with episodes of excitement. They are extreme cases, but in considering them one must take into account also the potential danger arising from the power of suggestion and the undesirable influence such children have over other children who, classed as normal, would not of themselves conceive abnormal acts, but are willing followers of their "brilliant", but irrational leaders. Therefore, if we are to safeguard the normality of a group of well-balanced children, we must remove the psychopathic child from contact with them.

Having considered the agencies with which every child comes into contact and found that they do not fill the need, we have two fairly well known sources of relief open to us—the social agency and the correctional institution. Of the

experience of both of these agencies with the border-line child, I could write at length, feelingly, and with eloquence, from my own experience as case supervisor in a social agency that performs a twofold function—doing preventive work with juvenile delinquents in the community and acting as parole custodian for a juvenile correctional institution.

Let me briefly outline just what happens when a distracted mother or teacher decides to appeal to a social agency for advice and assistance in dealing with "Johnny". The agency, with a vision of correct social-case-work technique, does its honest best, with the following results: a trained worker spends from two to four hours on a detailed history of Johnny's personality, parentage, and infantile diseases; a physician taps his lungs, listens to his heart, and refers him to a neurologist, who in turn refers him to a psychologist, who refers him to a psychiatrist, always attended by the case-worker. Johnny's record in the files of the agency becomes voluminous, and we learn that he has no organic physical condition, a normal or perhaps superior intelligence, and an undiagnosed emotional instability. At least two weeks of examinations and concentrated effort on the part of the agency are followed by anywhere from one to four years of effort to adjust Johnny to his environment. He is transferred from school to school; sent to camp and returned as too difficult a problem; admitted to a convalescent home and discharged because he does not conform to routine; until at last the distracted case-worker throws up her hands and appeals to her supervisor, who has nothing to suggest. Where can we put Johnny? Meanwhile, Johnny's parents decide that social agency number one does not sympathize, and tries social agency number two, which runs Johnny through much the same mill, with the same result, and he journeys on to social agency number three. He is quite apt to keep up this cycle until he is too mature to hope for any further adjustment.

To prove that this is not an exaggeration of facts, let me cite the case of J.S., referred to our agency by the Bureau of Attendance. Investigation disclosed a post-encephalitic psychosis, plus a deterioration that prevented any establishment of an intelligence quotient, and a conduct disorder that absolutely prohibited association with normal children. In

spite of these discoveries, the social-service exchange reported that four other agencies had been interested in J.S., and the reports from those agencies showed that each had made a thorough study of the child, arriving at the same conclusion as those stated above, and that each had made a recommendation for commitment to a type of custodial institution *that did not exist.* As a result, J.S. was left upon the hands of an intelligent, but neurotic mother, until, in sheer desperation, she signed an application for his commitment to the Children's Hospital (for mental defectives) at Randall's Island, although she knew as well as the agency who had advised her and the physician who had committed the child that this institution had no facilities for the individual care such a case needed and that the child possessed qualities that would make him a decidedly troublesome element in the institution.

Now let me discuss the other disposition of this problem—commitment to a juvenile correctional institution. It often happens that a distracted parent, not understanding the abnormality of the child, feels that he must have discipline at any cost and, knowing no other course, has him arraigned in the children's court, where again he runs a gauntlet of examinations, investigations, remands, and probations—which, with his lack of judgment, he consistently violates—until finally a reluctant judge commits him to a correctional institution, where the trouble begins.

As a specific instance, I present D.R., who, committed to a juvenile protectory, failed to conform to the institutional routine, and had so little organic control that he could not hold his head erect and the institution was forced to provide a brace. After two years of failure, he was paroled, simply to eliminate him as an undesirable inmate. Therefore, two more years deteriorated and less adaptive, he was returned to the same environment from which he had been committed, with a dull-minded, apathetic mother and an antagonistic stepfather for guardians. He was re-enrolled in the public school and discharged within two weeks as absolutely uncontrollable and a public menace. Complaints of his attacks upon the neighbors' children were brought to the attention of the parole officer, and it was only then that a thorough sifting of facts disclosed a history of encephalitis lethargica, antedating his

commitment to the institution by two years. A definite psychosis had in this case been treated from a delinquency standpoint at the expense of the school and the correctional institution.

Through the combined efforts of the teacher and the parole officer, this child was committed to the one institution that offers any facilities for the case of juvenile psychoses—the Children's Cottages, Kings Park State Hospital, Long Island. This institution reports on D.R., in September, 1925, as follows:

"This boy is still in the cottage and his behavior is fair, but he still gets into fights with other children and is openly homosexual. He is very bright, but answers thoughtlessly and requires a great deal of supervision. He has gradually improved, but still walks about with his head on one side and his mouth open; occasionally complains that his neck hurts him."

The superintendent comments: "In any opinion, the prognosis of this case is fairly good so far as the boy's social adjustment is concerned, provided the homosexual element can be successfully combated, but his physical disability of wryneck and speech defect will probably never be entirely overcome. I do not think that he will adjust in a natural environment because of his homosexual activity."

It seems hardly necessary to comment further upon the harm that this homosexual activity did in the correctional institution, where the boy's tendencies had an outlet upon normal boys.

The case of D.R., more than any of the others, convincingly demonstrates the need of more adequate provision for the care of these juvenile border-line cases, because it shows, in the one isolated instance in which such provision has been made, how much the community has been spared. There are cases like that of D.R. at Kings Park, where two cottages, equipped to handle twenty-five girls and twenty-five boys each, are set aside for the care of juvenile psychoses. These children are admitted on regular commitment and under the supervision of a trained psychiatrist, and are provided with activities, including kindergarten, academic and physical training, and occupational therapy, suited to their mental and

physical equipment. With such training these children can and do gain self-control, advance in school work, and are given the best possible opportunity to adjust. This experiment is too recent to be judged fairly and the prognosis is as yet uncertain. But surely it is better to segregate such children, during the formative and adolescent periods, in an institution equipped to study and understand them than to allow them free rein to vent their dangerous tendencies upon the community or to curb them unintelligently in an old-fashioned correctional institution, which looks upon them as transgressors of the social code and believes that their way should be made hard, for therein lies salvation.

If there is need of provision for fifty, there is need of it for fifty times fifty. When my agency alone reports twenty cases of post-encephalitis referred as delinquency problems in one year, and in one district alone, of ninety-two cases, lists twenty-five as definitely psychopathic and in need of more adequate care than our present facilities afford, and when, furthermore, wherever two or three social workers are gathered together, the conversation turns always to the crying need for better custodial care of our emotionally unstable children, surely it is neither impractical nor visionary to ask a state or a city to consider ways and means of giving these children proper or adequate care.

A children's psychopathic hospital on the cottage plan and with no obvious connection with a reformatory or a hospital for the insane would meet this need. Such a hospital, to be effective, should be confined to border-line cases which do not qualify for state institutions as psychotic or mentally defective, and should have an admission basis similar to that of a general hospital, with an intensive follow-up of the patients discharged. The present commitment system that functions for the Children's Cottages at Kings Park and the state institutions for mental defectives undoubtedly acts as a protection for the institution and the child, but does not admit the border-line child at all, and bars many actively psychotic children from the advantages of custodial care. Except in extreme cases parents will not "sign away" a child to an institution to be released at some future period at the discretion of some unknown physician. They would, however,

gladly place the child in a hospital for observation and treatment if assured that they could remove him at their discretion. While, of course, some children would be removed contrary to advice, it seems to me the percentage would be smaller than the percentage ruled out by a strict commitment. A long follow-up period would be indispensable and frequent returns to the hospital necessary, but with such an institution in Greater New York, our distracted parents would be relieved of the burden of attempting to care for psychopathic children and freed from the fear that these children might be stigmatized by a court record or injured by contact with adult insane. Social agencies would be relieved of fruitless expenditures of time, money, and energy, in a vain attempt to solve a hitherto unsolvable problem. And I do not think that it is too much to say that many children would be salvaged from the course of the criminal or the psychotic to a fairly adequate adjustment to life in their community.

Then, and only then, shall we know how to answer the question, "What can I do with Johnny?"

THE RELATION OF INTELLIGENCE TO BEHAVIOR*

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IN DISCUSSING the relation of intelligence to behavior, we must recognize the fact that behavior is merely a form of conduct as involved in social relationships. Irrespective of whether one is dealing with persons or things, conduct is the sum total of the reactions of an organism in and through living.

There is a great deal of difference of opinion as to what constitutes intelligence. Intelligence is frequently defined as the capacity to learn. A statement of the mechanisms involved in learning, however, is not the most adequate definition. W. Stern defines intelligence as the capacity for making conscious adjustments to new requirements. Thus he stresses the potentials for adaptation to living. This type of definition is a reasonably safe one. Thurstone offers a more profound definition, interpreting intelligence as the capacity to inhibit an instinctive adjustment, the power to shift the psychic gears in some way so that our primitive tendencies can be checked when they are out of harmony with social needs. Further, intelligence involves the capacity to redefine the inhibited instinctive adjustment in the light of imaginatively experienced trial and error. In other words, intelligence lays hold of an instinctive trend and by the use of fancy or imagination reinterprets it as possible for a future experience, thus redefining the trend for expression in appropriate word or action. Finally, Thurstone defines intelligence as the voluntary capacity to realize the modified instinctive adjustments in behavior advantageous to the individual as a social animal. Hence the main stress of Thurstone falls upon the idea of a voluntary adaptation of behavior, and an adaptation that is

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to the advantage of the individual, not merely as an individual, but as a socially functioning being.

Many a child gets into difficulty because his adapted behavior is calculated to bring advantage to himself and disadvantage to those around him. By Thurstone's definition, such behavior would not be deemed most intelligent. Nevertheless, it is only by testing out his individual adaptations in their relations to his social setting that a child can learn what is to the advantage of both himself and those around him. A boy in the classroom who seeks a little fun is striving after something he deems to his personal advantage. It takes him a little time to realize how much it is to the disadvantage of other children, not to mention the teacher. On the other hand, theories of discipline vary, as children learn on moving from school to school. Even adults have some difficulty in learning what are the social standards of conduct. There is a wide range of behavior criteria between classroom practices suggestive of social disorder and those indicative of implicit conformity for social advantage.

Many differences of opinion obtain as to the degree and extent to which intelligence helps children make their adjustments in behavior. Dunham, for example, in his recent book, *An Approach to Social Medicine*, states that "the human organism should be measured primarily by the supreme characteristic of intelligence". But his gauge of intelligence is economic efficiency. Economic efficiency and intelligence do not seem to me to have as close a relationship as he postulates. If one thinks of the correlations between the intellectual factor and the economic efficiency of the pugilist, on the one hand, and of the professor of an institution of higher learning on the other hand, one can only wonder how far intelligence serves as an index of potential or achieved economic efficiency. Dewey refers to "the growing importance of personal rationability or intelligence to moral theory, if not in practice". "If not in practice" has a saving grace. In theory, intelligence should be a guide to behavior, but in practical life we face the situation that intelligence is not a trustworthy guide to behavior. We demand high standards of persons who we believe possess intelligence, though we do not always expect their achievement. We look to intelligence as an outgrowth

of theory, but in reality we cannot count on the most intelligent children giving us the best patterns of behavior for a class.

Something more than intelligence is necessary. Huxley, with a certain amount of early optimism, commented, in *Evolution and Ethics:* "The intelligence which has converted the brother of the wolf into the faithful guardian of the flock ought to be able to do something towards curbing the instincts of savagery in civilized man." He did not say that it does or will; he had hopes in intelligence and what it should be able to accomplish. He relied, of course, upon a process of variation and development such as made the wolf the guardian of the flock.

A different point of view is expressed by those thoroughly versed in the newer theories of dynamics. To illustrate the altered viewpoint, I quote Dr. C. M. Campbell, of the Boston Psychopathic Hospital, who states: "The dynamic elements involved in the relationships of one human being to another are among the most primitive and deep-rooted forces in human nature. In this relationship the intelligence plays a small factor." In other words, from the standpoint of human dynamism, there are things more important than intelligence. Moods, emotions, and hidden desires are more effective in determining conduct and levels of behavior than is the direction of the intellect.

If we discuss the relation of intelligence to behavior, we cannot avoid the question of responsibility for behavior. Concerning responsibility for intelligence there is little to say; that is an accident of birth and freedom from injury before, at, or after birth. The development of intelligence may be dependent upon a large variety of social factors, including school environment, teachers, curriculum, and so forth. The responsibility for behavior must involve intelligence to some degree if intelligence is to function at all. If we believe that our actions depend upon neural patterns and that our conduct is in accord with what we ourselves believe and wish, then we subscribe to the old saying that the wish is father to the thought; it follows that behavior is in harmony with what one wishes to do. The only responsibility that inures under such circumstances is the responsibility that is attached to

the belief and the desire. I shall not go into the Freudian concept of the wish; it is sufficient to know, so far as responsibility is concerned, that one must stress the relation of existent wishes and moral conflicts in their relation to behavior. This holds true in the classroom, on the street, or in the church.

Some educators would say that the success motive is important as showing the worth of intellectual capacity in affecting conduct. Terman states, in his genetic study of genius, that superior children also rate above the average in character studies. Noting the combination of high character and superior intellect, one might assume a definite correlation, in terms of conduct leading to success. Terman, however, goes on to say that if one contemplates these children in terms of future success, as one measure of conduct and achievement, the correlation of general intelligence and inclusion in *Who's Who* would be very moderate.

In other words, the genius indicated by intelligence tests consists of unusual intellectual capacity, but it is not prophetic of rare achievement in later life, nor does it to any extent imply the rare type of behavior that theoretically might be expected of children with superior intelligence.

One can understand some conduct situations on the basis of multiple personality, emphasized by Morton Prince. There are many personalities in a unit; all do not function at one time; only a section of a personality dominates at any particular time. Children vary in their actions at different times as they do in personality make-up. At one moment one group of factors is functioning and at another moment another group. Thus, one may have in the mind antagonistic trends which influence behavior at different periods. A child may be very good when the music teacher is giving a lesson and very bad when a teacher of mathematics holds the scene; he may be very angelic in the environment of the Sunday school and an infant terror at home; he may be a leader in the boys' gang and shy at a girls' club; he may be courteous in a friend's home and show the greatest and most insolent selfishness in his own. In other words, different phases of his personality are exhibited at different times. Adults also are not always the same, but they are apt to be more con-

scious of their own variations in behavior irrespective of the continuity of the intellectual level.

Goddard, with his perfectly definite ideas upon feeble-mindedness, goes so far as to say, "Knowing the grade of intelligence, we may know the degree of responsibility." Contrast with that the more accurate statement of Healy: "It is now clearly perceived that our notions of right and wrong are inextricably mixed up with social judgments and with the evolution of social relationships." In other words, conduct and behavior have as their criteria, not intellectual measures as a basis, but social judgments; responsibility cannot be determined solely in terms of intelligence, but calls for other valuations. This view is well supported by Thorndike in the statement: "The basis for moral conduct is partly inherited or born in us and partly acquired by us. The inherited basis is our instincts, our general predisposition towards a higher or lower grade of intelligence, and the nature of what particular predispositions toward moral conduct there may be in us apart from experience. There may be, too, apart from evident instincts, particular types of mind, particular combinations of qualities which we have at birth, which may push us towards virtue or vice." Intellect is very much sidetracked when one gets the point of view that there are predispositions that may push one towards virtue or vice. It is clear that all men are not born in the same moral class. The same type of conduct cannot be expected of all children, nor is the same moral education applicable to all.

If this view be correct, there arises the question as to what information the intelligence tests give concerning intelligence. In the first place, it must be remembered that intelligence tests do not establish diagnoses. They are instruments for finding out something, but just what that something is awaits a final determination. Intelligence tests do not measure all conduct; they do not determine the underlying moods of a child nor what his wishes, his habits, and his responsibility are. Recently I saw two boys of approximately the same age, one with an I.Q. of 72 in the third grade and another with an I.Q. of 88 in an ungraded class. What did the intelligence test tell? The former child had a great deal of character and tried to utilize all his power in school work,

although the tests revealed that he did not belong in the third grade. The second boy did not apply himself and had characteristics that the tests did not reveal. He evidenced on achievement tests an ability indicating fitness to be in the third grade. The difference lay in this: one was a gentle, sweet soul who did what he was told and was always dependable, and who was promoted on behavior rather than on ability; the other was restless, irritable, and always a disciplinary problem, and had been demoted. Their intellects had little to do with their behavior. If intelligence were a dominant factor in behavior, the one with the higher I.Q. should have been the better behaved child. Their inherited instincts and emotions, their relative differences in response to external stimuli, accounted for the incompetent being above his proper grade and the more competent one below his place.

Intelligence tests often reveal merely what a child will do and not what he can do. Different examiners may secure varying results, and as a consequence there may appear an apparent inconstancy of the I.Q. Lately a boy in an ungraded class was found to have an I.Q. of 101, while six months previously he had been refused admission to the regular grades because he had failed to secure a satisfying result on a test and had been deemed deficient intellectually. He had failed because of emotionalism and not on account of intellectual incapacity. What he would do and what he could do were not identical. One must bear in mind that an intelligence test in itself is a conduct reaction, because emotions enter into the testing. They move in and out of the personality of the child being examined, and they move in and out of the personality of the examiner; and the combined reactions sometimes lead to results that have to be interpreted with a great deal of caution.

Intelligence tests do not reveal the basic phases of character. Measures of conduct are dependent upon social ideas and ideals, upon our customs, habits, and laws. For example, there never was any truancy until there was a mandatory educational law. Consequently, society created a new misdemeanor, a new trait of character, when it established the law, "You must go to school." Old writings do not refer to truancy. We have created it, and social edict has established

it as a form of delinquency; one notes an increase of truancy in this country along with an increased inflexibility of our educational laws. But have the boys of this generation weaker characters because truancy has increased? They have the same characters, but are subject to a new set of social demands; we, therefore, note in them a new set of social reactions which their fathers did not evidence, even though they may have played hookey.

Feeblemindedness is not a satisfactory basis for a judgment of conduct. There was a time, a few years ago, when one could explain anything by just saying "feebleminded". It was a wonderful explanation because it seemed to solve so many difficulties. If a child stole, he was feebleminded; if murder was committed, the murderer was feebleminded; if a child did not want to go to school, he must be feebleminded; and if he did go to school and exhibited unpleasant behavior, surely he must be feebleminded. Feeblemindedness was a sufficient explanation of all these things.

Feeblemindedness often is a question of geography. One can be feebleminded in a city and normal-minded in a rural environment, feebleminded in one school and not in another school. A school that prides itself upon the fact that the median I.Q. of the primary grade is above 120 will have feebleminded children with an I.Q. of 95, because such children will fall just as far below the standards of the school as the child with an I.Q. of 80 will in an ordinary school where the average is below 110. Feeblemindedness is, partly at least, a question of geography. Binet himself wrote that the French farming peasant may be perfectly normal on his farm and feebleminded when he reaches Paris. That is true of a great many people. Primitive man did not have quite such complex intellectual reactions as modern man; and modern man's reactions show that he has built up his environment too much and has not developed adequately within himself. When there is less disparity between the mind and its sphere of activity, there is less evidence of feeblemindedness.

Generic traits are not constantly exhibited by children; no children are all good and none are all bad. With a fairly constant I.Q., one would expect some degree of uniformity

in conduct, but I see no evidence of that complete interrelation. Practically, conduct can be measured and interpreted only in terms of conduct. Carl Murchison, in his very interesting study of criminal offenders, first offenders, and recidivists, found that the repeated offenders had a higher standard of intelligence than the first offenders. If there is any relation between intelligence and conduct, what does this mean? The recidivist is repeatedly caught after failing to exhibit much intelligence and yet he possesses a higher intellectual ability than the average run of first offenders. A high degree of intelligence is often found among those who are repeatedly breaking the social laws, and this holds true for the young as well as the old. Feeblemindedness cannot be deemed the cause of crime among either white or Negro criminals.

Both intelligence and behavior are affected by many factors. Some students believe that intelligence reaches its acme along with physical growth. When does physical growth reach its acme? Some are accustomed to think of fourteen or sixteen years as marking the end of our intellectual development. I doubt this demarcation. The curve of intellectual growth is not completely developed at the age of fourteen or sixteen years. It would be strange to have it stop at this point. No one could convincingly state that intelligence at the age of twenty-one is not higher than that at the age of fourteen or sixteen, even if one thought only in terms of intellectual machinery. Let us rather admit that we lack dependable scientific measures to determine the intellectual capacity at higher age levels. If one wishes to assume fourteen or sixteen years as a basic age and calculates intelligence quotients on that basis, one must not forget the danger involved. In all probability intellectual power develops for an indefinite period, just as do the physical structures and their functions. Underlying all growth is some common factor whose mechanism and mode of operation are still to be revealed.

Conduct is a larger concept than intelligence. It is not merely an association of neuron patterns for some definite function that involves association, memory, reason, judgment, and so forth. Conduct is interaction—the sum total of our reactions in and through living; and intelligence is merely one of the elements involved. As living organisms, we alter

our conduct when subjected to new stimuli, new situations, new places, new ideas, new experiences. Conduct is constantly bubbling like water in a kettle over a flame; one never knows when it will spill. If, therefore, we accept the fact that, under ordinary circumstances, numerous factors condition and enter into conduct, the bright child cannot be held to any different standards of behavior from those to which we hold the dull child. There are many different methods of approaching children of various intelligence levels to secure an alteration of conduct, but the inner forces, the instincts, the emotions, the responses to external stimuli, may be as powerful among those who are mentally dull as among those who are mentally keen.

Viewing conduct, one is warranted in rejecting its interpretation wholly on the basis of intelligence. Situations change when a dull boy is placed in too high a class. His behavior may have been perfectly satisfactory until he was advanced to the higher class, in which the teaching went over his head. Then he may develop irritability and playfulness, and suffer the temptation to put himself across by actions irritating to others. But he is little worse off than the bright child who is in a class below his capability and is bored by unstimulating experience; he may resort to the same type of behavior as the dull boy as an expression of his discontent. Thus one may find dull and bright types exhibiting similar phases of behavior because of an internal unrest, due to an inadequate correlation between intellect and the demands made upon it.

Intelligence and behavior may be affected by a common pathological factor, such as an attack of encephalitis or sleeping sickness. Encephalitis brings about profound changes in character and personality, in intelligence level and conduct. A sweet, charming girl is stricken by encephalitis, and she is transformed; having been an angel before, she now manifests many characteristics of a devil. Her thinking is uncertain; her inhibitions are weakened; she will wander about in the classroom, talk without permission, hit some one, disregard earlier training, start a fire in the halls, or otherwise make school life hazardous. Before her attack, she may have had an I.Q. of 140, and after her attack, it may be below 100. In other words, the same cause has affected both her intelligence

and her conduct; both are beyond her control. A sensory defect may condition intelligence and conduct.

I have just referred to a sight-conservation class a boy with nystagmus. His oscillating eyes cannot fix on anything. This child had been going to school for a few months; the teacher noted that he was learning very little and was restless and uncontrolled. The ever-moving eyes could not settle on a word long enough to see it clearly; and the very effort at fixation irritated the boy and made him restless and unhappy. Keeping him in an ordinary class would mean the continuance of ineffective learning, with an increase of nervous irritability and probably a growing disregard of ordinary discipline. By altering his class environment—so far as possible stressing auditory direction rather than visual impressions—one tends to lessen the visual strain and its consequent manifestations. Conduct and intellectual growth are both influenced by defects in any of the sensory mechanisms. I need only mention the unfavorable effects of malnutrition upon behavior and learning.

Intellectual development and behavior may be affected for better or worse at one or another school. Poor teaching and poor teachers handicap the development of a child's mentality and may lead to undesirable behavior. It is equally true that a good teacher may aid intellectual progress and secure better classroom reactions. Over-crowded classrooms, lack of individual attention, weak organization of self-discipline as opposed to formal discipline, and part time affect behavior as well as school progress. I recall a boy whose interest in school was so undermined by part time that he took up theft as a relief from school work. When the part-time situation was relieved and he had full-time schooling, he regained interest in school and the inclination to theft subsided.

Teachers of exceptional children—the bright, the neurotic, or the mentally deficient—appreciate the importance of adequate gradation and the special adaptation of a curriculum to the needs of the children.

Intelligence may guide or balk behavior through the use of the reasoning power. The acceptance of ideals and high principles may lead to efforts at inhibition and at self-control. On the other hand, when intelligence begins to reflect upon

personal desire, irrespective of social interests, it may thwart social behavior. The desire for adventure is normal. How important is it to keep a classroom at rest while a parade is passing? How much studying is done? There is ever a contrast between disciplinary values and intellectual values. Intelligence may decide for or against self-discipline when conditions are more pleasant outside than inside the classroom.

Truancy may be an act of intelligence. I recall a boy who had been struck by a teacher; he resented the blow and played truant. This represented a reaction against injustice. Truancy may be the expression of independence and self-reliance. After all, many of the advances in the world have resulted from nonconformity, from striking at or jumping away from regulations. The boy I speak of had been hit by a teacher who violated the by-laws of the educational system; the boy took the matter into his own hands and stayed away in the afternoon. He decided that if he went back the next morning, he would be sent to the principal, who would not be over-gentle. So he stayed away another few days until a truant officer came upon him and he was apprehended. That boy was justified in his truancy. He had used his intelligence to escape an injustice. He could not return the blow of the adult teacher, so he regarded flight as legitimate. He knew he could not alter the school situation, as loyalty would compel the principal to support the teacher as far as possible in his discipline. The alleged truant was transferred to another school, and his school attendance has been exemplary. Did his I.Q. improve his behavior or make it worse?

Intellectual action and behavior may both be inhibited or modified by emotion—a single emotion or a conflict of emotions. An adolescent girl suddenly realized that she lacked beauty; she was failing in the race for social favors. She craved attention and suffered distress from her contemplation of what she deemed her own unattractiveness. Her dawning love life was in conflict with her desire for educational success. She could not conceive intelligence as beauty or as an attractive attribute, and her school work suffered. From being among the leaders of her class, she was threatened with demotion. She had not learned that one can be attentive to one's own looks and one's books at the same time without very

much of a conflict, because she had been afraid to discuss her difficulty. Emotional stabilization was rapid and was followed by renewed intellectual effort after she had revealed her personal emotional struggle.

Fears, or even the emotion due to woolen underwear, may interfere with intelligence and behavior. The emotional response to a headache, a toothache, or a scolding at home may inhibit effort at study and stimulate unpleasant exhibitions of behavior.

I recall a youngster who, after his first explosion in school, was promptly rushed out to have his I.Q. determined. He was found to be mentally dull. Three weeks later, he had an I.Q. of 127. His behavior and intelligence had both flown at the same time; both had returned at the same time. It is evident that a lack of interest or increased emotional stress affects both intelligence and behavior.

One specific ability may safeguard the personality and conduct of a dull child. Many a child is redeemed because he can do one thing well. A boy who is physically restless, disliked by other boys because he cannot throw a ball, may behave normally because of a real ability to play the piano. Or a girl may be able to conduct herself with self-respect because she can draw, sing, sew, or do some one thing well. Many a child is rated higher than he deserves because he can read, and many a one is retarded because he has no gift for arithmetic. Writing, for example, is not important. The relation between writing and intelligence is a minor one. When the manuscript system was first introduced, many children had two systems of writing, one for the school and one for the home. They wrote manuscript forms at school, but at home they wrote as they pleased, especially when they had something to reveal. Their intelligence and conduct were on two planes of habit formation. It is patent that special abilities and disabilities may determine conduct and intellectual function.

One must admit that intelligence, in so far as it affects behavior, does so by reason of its adequacy or inadequacy in special situations; and its adequacy or inadequacy is affected by some things favorably and by other things unfavorably. The innate dispositions and personalities of children are far

more important than their mere intellectual machinery, although intellect is part of the personality. Intelligence, conduct, and behavior are determined to a large extent by external stimuli arising from parental and school examples, companionships and friendships, familial restraints and social taboos. Acquired patterns of behavior act upon and through deep instinctive trends, accompanied by their lively emotional tensions. In addition to these innate factors—in addition to native intelligence and its adaptation trends in conduct—childhood is subject to the stresses of disease and accident. Organic and functional diseases may disorganize intellectual function and alter personality seriously, so that conduct is apparently inexplicable in terms of intelligence. Speech defects, defects of hearing and vision, weakened function of the heart and lungs or other viscera, or the wide range of neuroses profoundly affect behavior without any serious impairment of the intelligence.

It is obvious that teachers should stress intelligence and seek explanations of behavior in terms of relative intelligence ratings. The fact remains, however, that intelligence is only a single element entering into behavior and cannot be regarded as the most important factor. A child's behavior may be conditioned by his intelligence, but it cannot be explained by it alone. Intelligence is reflected in behavior, but behavior mirrors far deeper springs of action than well up into the plane of intellect.

PHYSICAL FINDINGS IN PROBLEM CHILDREN*

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PRACTITIONERS of medicine are often confronted with children who exhibit problems in social adjustment. These children are presented for examination and treatment by anxious parents, by truant officers, by teachers, by social workers, by juvenile-court authorities, often with the expressed belief that some remediable defect may be found the removal of which may prove a cure. Every practitioner has met such cases, and occasionally he finds that the removal of a physical defect does seem to contribute to recovery. To be sure, other factors are very likely to enter into the equation, and even in those cases in which the physical disability is largely causative, the removal of the defect will not effect a cure. Grooves have been worn in the mental and nervous mechanisms which perhaps time and the employment of new procedures may efface.

Heredity plays a much slighter part in behavior maladjustments than was formerly thought to be the case. Frequently, however, cases of physical deviation, mental dullness, and other twists can be explained on this basis. On the other hand, the child's environment may be the cause of the social havoc, even when his heredity may leave little to be desired. Herein are interesting fields for the psychiatrist, the psychologist, and the psychiatric social worker. But under numerous circumstances in which such experts are not available, the general practitioner is called upon, not only to remove remediable defects, but also to advise and even to adjudge.

This paper, which is based upon a study of 300 problem children during the year of 1924, gives data with regard to the physical defects found in association with behavior prob-

* From Child Guidance Clinic No. 1, Los Angeles, Cal., a demonstration conducted (Jan., 1924–Jan., 1925) by The National Committee for Mental Hygiene, Division on the Prevention of Delinquency, as part of the Program for the Prevention of Delinquency of The Commonwealth Fund.

lems. The physical examinations were made almost entirely by volunteer pediatricians. The children accepted by the clinic were of various types, pre-school, pre-adolescent, and adolescent. Very few were mentally defective or had court records. The misconduct ranged from minor behavior reactions based on poor habits formed at home to more serious offenses, such as stealing and sex behavior.

DEFECTIVE NUTRITION

Of the 300 children, 108, or 36 per cent, were found to be poorly nourished. The relation of *malnutrition* to conduct disorder has been commented upon by many observers. Not only is post-natal malnutrition to be considered, but we must also remember that under-nourishment of the mother during pregnancy has a bearing on the child's nutrition and may produce defective tissues, particularly of the nervous system. Because of this under-development, these tissues are ill prepared to withstand the pressure imposed upon them in after years. It is our impression that post-natal malnutrition in the case of such children is largely the result of the same factors that contribute so much to their maladjustment—namely, inadequate training, lack of parental control, inadequate dietary, poor physical and mental hygiene.

Forty-one, or 14 per cent, of our series were classified as over-nourished. A number of these were undoubtedly to be regarded as cases of endocrine dysfunction; others were thought to be the result of dietary errors. Some of these over-nourished children were also found to be *over-developed.* It is apparent that the over-size of these children is in itself a handicap to normal mental and social development. The over-nourished or over-developed child is frequently contrasted with other children. This often affects the child and he becomes shy and seclusive or develops inferiority feelings, so that he may be considered dull. He may be actually physically and mentally sluggish because of endocrine imbalance. Of over-developed girls, a corresponding hyper-development of the sex organs is likely to produce complications. The treatment includes not only dietary measures and endocrine therapy, when indicated, but also the placement of the child

in a mixed-grade room where the size disparity is not so obvious. The following is an example of cases of this type:

CASE RECORD

X, white boy, ten years, nine months. American parentage.

Problem.—He is lazy, dull, inattentive, obscene; he lies, steals, and indulges in sex practices.

Ancestry.—Two grandparents were college graduates. There is no history of alcoholism, syphilis, or mental disease. Father was a high-school graduate, died of nephritis at twenty-four. Mother was raised in a convent; she is pretty, audacious, intelligent, poised. Her home life is happy. No siblings.

Development and health.—Instrumental delivery, bottle fed; walked, talked, and teethed under one year. Influenza at five, followed by nephritis; good recovery. He has always been a large, fat boy.

Habits and conduct.—He sleeps and eats regularly. No fears, masturbation, or enuresis. He does poorly in school, is obscene, makes friends with bad boys and truants. He lies and steals from other children, from his parents, and from shops. Runs away from home and has knowledge of sex perversions.

Physical findings.—He is large and overweight; his extremities and pelvis are of female type; he is suggestive of mixed thyro-pituitary imbalance; otherwise the physical findings are negative.

Treatment.—Medicinal for endocrine imbalance; dietary; hygienic régime. Stimulation of ambition by vocational training; physical hardening by gymnasium work or out-door play with some "Big Brother"; opportunity for religious background and training.

Note: After but six weeks of treatment, patient has lost weight, has become more alert and active, and has taken on new interests.

Twenty-four cases in our series, or 8 per cent, exhibited a symptomatology that could be conservatively ascribed to *endocrine imbalance,* and 24 were questionable cases. With increased knowledge of such disorders, others of our patients might be so classified. Neither the unwarranted conclusions of a few enthusiasts nor the pretentions of blatant manufacturers of gland extracts should deter the thoughtful physician from employing these valuable agents when they are indicated.

OBVIOUS PHYSICAL DEFECTS

Of obvious physical defects there were noted facial birthmark; harelip; clubfoot; post-encephalitic, post-poliomyelitic, and post-meningitic palsies; birth palsies; and supernumerary fingers. The lesser "stigmata", such as ill-formed ears or facial asymmetry, were recorded but thirteen times. They were present much oftener than was indicated in the histories, but the scant importance attached to them as indicators of

mental defect or personality difficulties accounts for the small number recorded.

It would seem apparent that obvious physical defects are of importance in a group such as ours because of their tendency to produce feelings of inferiority. In this respect we believe that they are of considerable importance; and the physician can be of great service by seeing to it that patients whose defects cannot be remedied are given a training that will help them to excel in some particular line, so that their self-confidence and self-respect may thereby be preserved.

HEART DISORDERS

Irregularity of the heart and adventitious heart sounds were heard in 37, or 12 per cent, of these patients, but in only 4 were they thought to indicate well-defined heart lesions. All the hearts were compensating. Unfortunately, a number which were producing inconsequential whiffs had been diagnosed previously as pathologic, and decided fear reactions had resulted, both in the patients and in the parents. In this connection, it is well to recall that many children have been unwittingly condemned to lives of semi-invalidism by such diagnoses. When dealing with such disorders, we should not lose sight of the fact that it is the common belief that the heart is a very fragile organ. In view of the now well known ability of the non-acute heart to meet the usual demands made upon it, it would seem that the physician is often justified, especially when dealing with children, in withholding information that relates to cardiac disorders from the family as well as from the patient. A case in point is the following:

CASE HISTORY

Y, eleven years, nine months. French-American parentage.

Problem.—Extreme dependence on his mother. He is jealous of a younger sister and is guilty of sex attacks on her. He is emotional, unstable, and untruthful.

Parentage.—Father died of tuberculosis when patient was nine years old. Mother was infected with tuberculosis, and was an active case at the time of the father's death, but is now inactive. She is French born, college educated; she is neurotic, introspective, and apprehensive. She reads popular current literature on medical subjects, psychoanalysis, and so forth. Six months ago she was told by a physician that the patient had a heart lesion; whereupon her apprehensive fears were increased. She talks the problem over with the boy, and they read together such medical literature as she

can procure. She insists on an over-strict adherence to the regimen prescribed by the physician. The boy is not allowed to run or play, is scarcely trusted out of her sight, and is not even permitted to play the violin—the activity of greatest interest to him.

Physical findings.—The patient is well nourished, of good, but not robust appearance. He is alert and of quick movement. There are no outstanding physical defects other than a discharging ear from an old otitis media. There is a slight systolic mitral murmur; the heart fully compensates. Of this bruit he is apprehensively conscious, but rather boastful, using it as a defense against his school failures.

Comment.—It is apparent that we are dealing with a boy who has an imposed chronic invalidism which has resulted in feelings of inferiority.

Treatment suggested.—An attempt to instruct the mother and to obtain her coöperation in instituting a rational therapy. Failing this, removal of the patient to a new environment if possible.

Note: This latter method was finally employed, with encouraging results.

HISTORY OF PREVIOUS ILLNESSES

Of the 300 children studied, a knowledge of previous illnesses was denied in 14 cases, or 5 per cent. A few of these children had been adopted, and the previous history was unknown. Of the remainder, it is possible that the parents had either forgotten or that they misrepresented.

The maladies of the individual patients ranged from an uncomplicated attack of measles in one case to 12 febrile disorders (including meningitis, diphtheria, and pneumonia) in another.

The sequelæ of these acute infections frequently assumed an obvious importance. There was noted a strabismus following a meningitis; spasticity resulting from a cerebral hemorrhage; palsies subsequent to a poliomyelitis; intellectual blunting, the sequal of an encephalitis; and deafness incident to an otitis media.

In this connection it is well to remember that encephalitis is frequently diagnosed as an influenza or other febrile disorder. The post-encephalitic manifestations that occur, such as nocturnal restlessness and sleeplessness with diurnal drowsiness and irritability, are sometimes attributed to willful misconduct, as in the case below:

CASE HISTORY

Z, white boy, fifteen years. Roumanian parentage.

Problem.—Not amenable to discipline, irritable; sleepless at night; runs away from home; steals.

Development and health.—Full term, normal weight, normal delivery;

dentition began at six months; walked and talked at eighteen months. Had measles at eight years. Was well until twelve years old, when family noted restlessness at night, accompanied by drowsiness in the daytime. He was irritable and awkward. He drooled and complained of fatigue and headaches. For the last three years these symptoms have been present in varying degrees. His irritability and his nocturnal restlessness are still outstanding. He reads incessantly, good books if he can get them. He has been caught stealing books from the public library. He is erratic, and he indulges in obscene language and songs. His moods are variable. At times he is very serious, at times quite facetious.

Physical findings.—He is poorly nourished, has marked dental caries and flat feet. He has a diplopia at 10 inches; narrowed lateral vision; nystagmus. The discs show a dullness on the outer left and inner right sides with congested fields on the opposite sides. The muscular movements are slow and awkward; the face is masklike. There is a tremor of both hands and the speech is thick.

Comment.—It is apparent that we are dealing with an old encephalitis, which has been undiagnosed. The boy's misconduct is thereby readily explained.

Undoubtedly, previous illnesses may be the starting point for behavior problems and antisocial acts. Some few are directly traceable to the disease processes; but much conduct disorder is the result of the slacking of parental discipline incident to ill health.

In the absence of controls, it is difficult to determine whether the diseases of childhood were more prevalent in this group than they would be in a similar number of well-behaved children of similar social grouping.

DEFECTS OF THE GENITO-URINARY SYSTEM

There were in our series but 2 cases of syphilis, as indicated by positive blood Wassermanns. The fact that the clinic studied few patients with mental defects may account, in part at least, for the small number of positive findings. Two cases of gonorrheal vaginitis were found in the group. There were 9 cases of prepucial adhesion and but 2 cases of phimosis. In 84 children, or 28 per cent of the group, enuresis was complained of. Masturbation is looked upon as a habit common to practically all children at some time in their lives. The rôle of adhesions and redundant prepuce as causative factors in masturbation and enuresis has been much discussed. It appears that as etiologic agents they play an exceedingly small part. The treatment is basically habit training through

encouragement and régime, not by inspiring fear and shame. A better insight on the part of the individuals with whom the child is associated is of paramount importance in better habit formation. Circumcisions in the male and ablations of the clitoris in the female, as curative agents, before an attempt has been made to understand these children and adjust them, are to be largely condemned.

DEFECTS OF POSTURE

Defective posture was recorded 137 times (46 per cent). Marked lordosis was noted 21 times (7 per cent); scoliosis, 8 times (3 per cent). In nearly all of these children, there was an accompanying poor musculature. There were 8 cases (3 per cent) of bowlegs, and 27 cases (9 per cent) of flattened feet that required treatment.

OCULAR DEFECTS

Forty-three, or 14 per cent, of these children had defects of sight. A number of those in whom this defect had not been previously recognized were found to be in lower grades in school than their ages and mental capacity warranted. It appears probable that an earlier recognition and correction might have prevented this misplacement.

Strabismus was observed in 13 instances (4 per cent). This disorder, like most objective physical disorders, undoubtedly enters as a factor in misconduct more frequently than is usually recognized. These children feel keenly the coarse humor of their fellows, and not uncommonly they develop defense reactions which get them into trouble.

DEFECTIVE HEARING

Only 9 cases, or 3 per cent, were found to have marked hearing defects of both ears, and all had been previously recognized. Successful treatment is often impossible, but competent aurists can frequently improve the condition.

It should not be forgotten that children may have defective hearing which has not been recognized by parent or teacher, and the child, because of his infirmity, is unjustly accused of mental sluggishness. Chronic otitis media in one or both ears

was found in 16 children, or 5 per cent. This condition, so often amenable to treatment, may be caused by a focal infection the removal of which may permit unhampered physical development and better use of the mental faculties.

DEFECTS OF THE NOSE AND THROAT

A small number of this group showed breathing obstruction due to septum deviation, enlarged turbinates, adenoid growths, and the like. Many had had their tonsils removed and a few bore the results of inferior throat surgery. When tonsils which were manifestly diseased were found, or when a history of recurrent tonsillitis was given, removal was recommended. In the aggregate it seems to us that in spite of the brilliant results occasionally observed after tonsillectomy and adenoidectomy, throat conditions have assumed a place in the list of physical defects of childhood entirely out of proportion to their importance.

DEFECTIVE TEETH

Practically every case of this series showed some evidence of dental defect, this in spite of the wide propaganda now carried on in favor of keeping the teeth healthy. These faults were of all degrees of unhygienic condition, from food accumulations to ginghival abscesses, severe caries, and pyorrhea. Considering the fact that these patients came largely from the middle class of society, for whom economic strain is the exception rather than the rule and dental care is available, it is evident that the almost complete absence of oral hygiene must have been partly at least the result of the same causes as the misbehavior—namely, hereditary fault, poor hygiene, and defective training.

SPEECH DEFECTS

Thirty-five, or 12 per cent, of the series had mild or gross speech defects. This condition was often found associated with an emotional make-up of the child, psychic trauma, and imitation of others. As a causal factor in children's problems, defective speech should be given the consideration it deserves. It may produce inability to get along well in school and in

play, with resulting combativeness or antisocial acts. Or the sufferer may become hypersensitive, seek solitude, and live in a dream world, wherein he finds himself unhandicapped and dominant among his fellows. Happily, the now well-understood methods of curing the affliction place in our hands a potent therapeutic weapon. As a matter of practical application, the physician is often in a position to prevent the worst type of aggravation of the disorder—that is, mimicry and ridicule. Nothing but an enlightened population can entirely efface this cruel practice.

The impression that one may get from examining such a group of children is that there is not a great deal of relationship between physical defects and behavior maladjustment. This impression is due to the fact that there are apparently no more physical defects encountered among these children than among normal children. But when one remembers that there probably is a "threshold" in these deviations as well as in diabetes or nephritis, then it becomes apparent that physical defect may play a very important part. Power of resistance is a quality that varies with the individual; even extreme physical deficiency may be tolerated in a person with a high resistance to wrong environment, while to one with a lower resistance, the result may be maladjustment.

It is obvious that other factors, such as poor home training, domestic conflicts, educational difficulties, mental make-up and conflicts, and so forth, enter into the problem; and only by careful analysis of the social, educational, physical, and mental factors at work can one hope to determine what is at the root of the child's unusual behavior.

SUMMARY

1. Of 300 children studied, all showed some physical defect, many of which were remediable.

2. Defects that tend to produce feelings of inferiority are of great importance.

3. Fear engendered in a child by the knowledge of a heart lesion is of clinical significance.

4. Endocrine imbalance may play an important part in social maladjustment.

5. Misconduct may be occasionally accounted for by an unrecognized encephalitis.

6. Ocular, auricular, or speech defect may be contributory.

7. Physical defect associated with faulty home training, domestic discord, educational difficulties, mental make-up and conflicts, and the like, may account for social maladjustment. An analysis of the whole situation is necessary before one can institute proper treatment.

THE SIGNIFICANCE OF PHYSICAL DISEASE IN RELATION TO BEHAVIOR PROBLEMS

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IN this age of changing scientific opinion, many tentative explanations as to the cause of disease are offered which later must be modified in the light of newly revealed facts.

It is, therefore, not surprising that certain factors in the causation of disease assume varying degrees of importance as time passes.

The human constitution is so complex and the parts so interrelated that disturbance of special functions or breaks in the orderly integrating processes may arise from different causes which produce more or less similar effects. On the basis of the symptoms present, it is not always easy to separate conditions due to focal infection (abscesses localized in the teeth, tonsils, and so forth) from changes produced by disturbed chemistry in the body, metabolic or endocrine disorders. Consequently there is some danger of placing too great stress on one particular group of disease-producing agents, unless special care is exercised in studying the body as a whole.

In the field of mental medicine much has been said recently regarding the biological unity of the organism and the need for approach to mental reactions from various angles. This had led to research into the possible influences on behavior emanating from the many physical and psychological sources. Some interesting conclusions have been reached, but many are as yet incomplete.

Reports of even partial investigation may be of much significance, but the value of such work diminishes when broad, sweeping conclusions are formed, based on only one phase of the problem.

There has been an increasing amount of literature appearing of late which tends to show how specific acts in human behavior can be explained in terms of bodily changes. The principal fallacy in the logic of most of these reports lies in

their tendency to simplify the literal meaning of such reactions, to make the whole process direct—a stomach upset producing a mental depression, an increased amount of thyroid secretion explaining a maniacal attack. Some investigators even report "cures" of feeblemindedness following operations for cleft palate. Consideration of the more devious and indirect pathways of nervous energy, including the accompanying psychological changes, the relationship between increased secretion and the thinking process, with association of ideas, has been omitted in these explanations.

There is a very definite relationship between energy distributed through the sensori-motor level and the psychological forms of expression, but this relationship is of a complex and subtle character. It cannot as yet be measured by physical apparatus, despite the numerous experiments that have been performed with the psycho-galvanometer, and so forth. The subjective factor, the transformation of energy within the body, cannot be examined by these methods.

In the work of the Minneapolis Child Guidance Clinic, an effort is being made to study behavior problems in an objective manner, through observation of all of the factors that seem in any way related to the personality of the child.

For the purpose of detecting whether any physical changes are present that might in any way condition behavior, it has been the policy of the clinic to enlist the services of a corps of trained specialists, and to include in each case study a general examination, more minute and specialized examinations, X-rays, and laboratory tests wherever these are indicated. Many cases are given metabolic tests, blood chemistry analyses, and so forth, even though the usual clinical indications for these procedures are lacking.

In summarizing the conclusions of these examinations, one cannot help being impressed with the relative scarcity of active physical disease as compared with the marked behavior disturbances manifested.

Throughout the year an effort was made to ascertain what relationship existed between the physical condition of the child and his behavior. For the most part the children referred to the clinic were not suffering from any physical illness that the child or his family were aware of. In fact,

some of the worst behavior problems and the most marked delinquencies occurred in robust children who were thought to be physically sound and with no history of serious illness. However, all cases were objectively studied, and physical examinations were made regardless of the child's apparent health.

In a very small number of cases, certain physical disorders were discovered which undoubtedly did have an influence on behavior. For example, one girl was found to be suffering from an insufficiency of thyroid secretion which seemed definitely to contribute to her general sluggishness and marked obesity. After thyroid had been administered over a period of several months, her weight decreased only slightly, but her general attitude seemed brighter and her manner more alert. Yet her fundamental personality traits remained essentially unaltered.

In a series of 100 cases studied, the physical findings elicited were as follows:

		Cases
Infected or enlarged tonsils		13
Adenoids or nasal obstruction		12
Visual disturbances		16
Hearing defects		4
Carious teeth		10
Dental malocclusion		5
Postural defects		11
Malnutrition		8
Structural or developmental abnormalities		30
Evidence of former rickets	5	
Umbilical hernia	2	
Deformities of skull	2	
Undescended testes	3	
Palpable spleen	2	
Thyroid palpable	7	
Polyglandular imbalance	4	
Albino	1	
Undersized body	1	
Inguinal hernia	1	
Obesity	1	
Phimosis	1	
Systemic disease	—	10
Rickets	1	
Mitral stenosis (compensated)	1	
Post-encephalitic sequelæ	1	
Mitral murmur	2	
Epilepsy cases—glandular (petit mal)	2	

	Cases	
Diabetes insipidus	1	
Urticaria	1	
Pylorospasm	1	
Negative physical findings	—	33

Of this group it was possible to demonstrate a direct relationship between physical condition and behavior in but four of the cases. The two epileptic cases showed some of the usual behavior characteristics associated with that disorder. The child who had passed through an attack of encephalitis apparently developed his undesirable behavior reactions immediately after the infection had subsided; and the boy with the diabetes insipidus showed characteristic reactions associated with his marked thirst and frequent urination. Even in these cases, however, the personality make-up and psychological motives could not be eliminated as important factors in the behavior of the child.

In the other cases there was no way of estimating quantitatively the influence derived from physical factors, although such conditions as infected tonsils may have contributed to the development of abnormal behavior. On the other hand, many of the children already had had their tonsils removed.

The particular point of significance in this group, however, was its similarity in character and degree of behavior deviations to the group of 33 cases which had negative physical findings. The children were referred for such problems as stealing, lying, truancy, sex difficulties, school maladjustments, and various "nervous" symptoms. In the children who showed no physical disorder, the problems included the same variety of disturbances. In one instance, attacks of unconsciousness occurred in an eighteen-year-old boy. His condition had been diagnosed epilepsy (petit mal) before he came to the clinic. After psychological analysis and treatment, with situational readjustments, the attacks disappeared entirely and have not again returned after several months.

In view of these findings, one may conclude that with reasonable precautions and after making use of the best facilities available for the detection of organic disease, there remains a group of children who show marked behavior disturbances, although they are apparently normal physically. They are

functioning physiologically as normal individuals according to the best known methods of examination, yet they manifestly are "sick" in terms of social and psychological efficiency.

In many cases the behavior was modified by the removal of mental conflicts or emotional difficulties. In certain instances, physical symptoms disappeared following psychological analysis and reëducation.

A FORM OF PSYCHOGENIC TIREDNESS

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IT is a well-known fact that much tiredness is of mental origin and is experienced when the actual physical capacity for work is but little reduced. This kind of tiredness is probably one of the greatest drawbacks to personal efficiency and cheerfulness of spirit and is in need of much more serious consideration by psychologists, psychoanalysts, psychiatrists, and educators. There is the child who easily gets tired at his lessons; the perennially tired housewife; the tired business man who cannot drag himself around the workshops, but who can do two rounds of golf in an afternoon; there is the nervous child who gets tired at play, the shy person who is too tired to go out to meet company, and the many others who are equally familiar to us. We need some one to make a thorough investigation into the causes of this "psychogenic" tiredness and then to tell us how those causes might be removed.

It is no such stupendous task that I am embarking upon in this brief article. My aim is merely an endeavor to account for one form of this psychogenic tiredness—namely, that produced by some particular person in another—with the hope that my observations may prove of assistance in explaining other forms of tiredness such as those cited above. Already a considerable amount has been written on the subject of mental and physical fatigue[1] with some reference to the tiredness of mental origin, but all the available information on this latter problem has not as yet been brought together and given a practical significance for psychotherapeutic purposes.

One often hears the remark about some one, perhaps otherwise an admirable and interesting character: "She just tires

[1] See, for example, E. L. Thorndike's *Educational Psychology*, Vol. III (New York: Teachers College, Columbia University, 1913–14); also *Mental Fatigue*, by Max Offner and G. M. Whipple (Baltimore: Warwick and York, 1911); and "The Present-day Physiological Basis of the Clinical Study of Fatigue", by R. D. Gillespie (*Journal of Neurology and Psychopathology*, Vol. V, pp. 103–14, August, 1924).

me out." Most of us know the feeling behind such a remark. There are people whose company is literally fatiguing. We like to be with them for a short time only, or we may find it an effort to be with them at all. One hears of children who are fatigued in the presence of their teacher, whether they are worked hard or not. There is the example, quoted by Frank Watts, of the employees in a factory who were tired in the presence of their foreman, and whose efficiency increased when he was away.[1] Why do some people make one feel tired? Or, more exactly, what kinds of personality cause one to feel tired and why do they affect us in this way? These are the questions that I asked myself and that I have attempted to throw light upon in the following paragraphs.

Looking through the psychological causes of fatigue as quoted by others, the one common and all-important feature seemed to me to be mental conflict. The moods, the emotional disturbances, the monotony, discontent, and other causes cited may all produce or be products of mental conflict. When two or more impulses are warring for expression, emotional tension is involved, productive action inhibited, and fatigue is experienced. We may find, then, that "fatigue-producing" personalities tend to set up mental conflicts in the people with whom they come in contact and cause to feel tired. With this suggestion in mind, I set out to analyze the situations in which I discovered myself being made tired by another person. This involved a study of the other's personality, his or her relationship to me, and a mental analysis of myself. Later I made similar analyses, as far as that was possible, of situations in which my friends or acquaintances were made tired by other people.

The results of my observation showed that, whatever other causal factors may operate to make one person feel tired in the presence of another, the factor of mental conflict is always present and is of extreme importance. The results showed, moreover, that, although upon casual observation, the personality of the individual who causes the fatigue is the chief source of the trouble, further analysis points to causes also

[1] "*Abnormal Psychology and Education*", by F. Watts. New York: D. Appleton and Company, 1924.

in the fatigued individual and in the relationship between the two people.

The following are my observations grouped according to the types of personality that cause the fatigue. They are presented in this manner in order to form a direct answer to the first part of the original question. But it must be clearly understood that the *true causes are only to be found in the total situation,* which includes also the personality of the fatigued person, the relationship between the individuals concerned, and even external environmental factors. Because of the importance of this fact, I have, in discussing each type, mentioned the kind of personality most affected by a person of that type. In two cases—one in which the cause of fatigue lies in the relationship between the individuals concerned and the other in which the cause lies rather in the peculiarities of the tired person—I refer to the type of situation as being fatigue-producing rather than the type of personality. After the description of each total situation, I offer a few suggestions as to how tiredness might be prevented or reduced in each case.

There is one type of person who is constantly demanding attention, who wants to be always "in the limelight" and the center of interest. If one is living in the same house with such a person and sits down to read a book, study, or write a letter, one is continually interrupted by questions and remarks which seem to one trivial and which are designed simply to attract one's attention. Such a person may chatter incessantly in company, endeavoring always to monopolize the conversation; or she may hold attention, when once she has attracted it, by being very slow and lengthy in her utterances. She will make heavy demands upon one's time, entirely regardless of one's business or other interests.

There are both men and women of this type. In some men it takes the form of wanting to play parlor or other games whenever there is a spare minute, and demanding that everybody shall join in. Insistence upon family games may have other and more laudable motives, but there is one kind of insistence that is largely determined by a craving to be entertained and to be first in everybody's thoughts. Such dominating ways are common in children and can be very tiring. The

reason for the fatigue, apart from physical reasons, may be found in the conflict between the desire to be kind and polite and the wish to be one's independent self, following one's own bent or turning to something new and more in keeping with one's interests.

The kinds of people most affected by this type are the self-contained individuals with private and absorbing interests of their own or others of the type demanding attention who are themselves impatient to become the center of attraction. These latter persons may feel tired when in the company of people who pay them no attention. The thing for the tired person to do in any one of these situations is to find out to which type he himself belongs and to learn to extend his interests to include those of the other people concerned. He can attempt to modify his own extreme tendencies, and, where the strong impulse cannot be modified in the other person, an attitude of kindly understanding and tolerance, with perhaps an occasional indulgence allowed to the other, will relieve the situation.

Another fatigue-producing person is the over-enthusiastic kind, who "takes all the wind out of one's sail" or who hustles one along at a hair-raising speed. This vehemence and enthusiasm will have different effects according to whether it is in line with our interests or not. It is more likely to cause fatigue when it is directed toward something that does not interest us. We may react to this situation in either of two ways, both of which are tiring. We may be "put off" by the zeal and enthusiasm, perceiving no hope of success in competition, and may resort to a defense of ridicule or apparent lack of interest in order to gain superiority in another way. In this way we evoke in ourselves what Adler [1] has called the "derogatory impulse", which tries to achieve superiority by thwarting the other person and belittling his endeavors. On the other hand, we may struggle to compete with the energetic one and be discouraged by the relative ineffectiveness of our efforts. The mental conflict aroused in us is between our desire to be friendly and our interest in the subject, on the one side, and our wish to excel on the other.

[1] *The Neurotic Constitution*, by A. Adler. New York: Moffat, Yard and Company, 1917.

Persons who would be made most tired under the above circumstances are those lacking in physical energy, mental abilities, or organization of interests, and those with a strong tendency towards self-assertion and a craving for personal success. The remedy for these people would be to find out if they themselves have this domineering impulse, regardless of whether the other person seems to have it. They would also need to discover their own abilities and disabilities and and learn to accept them. They should consider which competitions would be futile for them, so far as winning is concerned, and should try to be content to take a minor part in a worth-while cause if need be. They should take steps to remove their disabilities and at the same time cultivate their talents so that they could taste of refreshing success in their own fields. Sympathetic appreciation of another person's achievements is also a good fatigue dissipator. The energetic person would do well to try to curb any tendency in himself to domineer or "show off", and to develop a consideration for other people, with an appreciation also of their need for self-expression.

There is a type of person, similar to the energetic and enthusiastic type, who does all the giving between two people—who forces his attentions and services upon the other. He refuses to be pampered or looked after himself, but is always "fussing" after the other person. This may promote a state of self-absorption and irritability or complete lassitude in the object of attention. His own desire to do little services for a friend is denied active expression. A conflict is set up between this desire and the wish to be nice to the friend by letting him have his way, together with a desire for a certain amount of practical attention directed toward himself.

The sort of person who would feel restless and yet tired, or lethargic and weary, in such a situation is the person with a strong "ego instinct", who is fairly active. He would want to be *doing* whatever was to be done himself, in part for the other person, in part for himself. At the same time he would be flattered by the attention and would like to lie back and be waited upon. Under these circumstances a heart-to-heart talk would probably be the best remedy, followed by

the construction of a rough program to be carried out between the two involved on a "give-and-take" basis.

An individual with characteristics the exact opposite of those just described may also be very tiring. I refer here to the commonly called "selfish" person who is content to do all the taking, who expects to be waited upon and entertained and who never volunteers any services herself or himself. It is a very delicate question as to which is really the more selfish, the person who does all the taking or the one who does all the giving. This passive acceptance on the part of one individual of whatever is given may set up a conflict after a time in the mind of the giver. His own natural desire for motherly care and attention, being unsatisfied, will grow stronger and come into conflict with his affection for the other person and his wish to be kind and helpful.

Anybody who has had a pampered childhood or who has lived long with people who supplied all his practical needs will find the so-called "selfish" person fatiguing. His dependence upon a mother's care has been allowed to persist and he will crave for it when it is not given. The best remedy in this case is for him to learn to do for himself what other people have hitherto done for him. An attempt at adjustment in such a situation is often made unconsciously by the method of "projection". The individual may "project" his longing for a little attention on to some person of whom he is fond, that is, he may assume that there are cravings similar to his own in this person. He will then get spurious satisfaction out of indulging the supposititious (yet partly real) desires of the other person by excessive giving. In other words he will develop into the type of man or woman already described and popularly called "extremely unselfish". The behavior itself is pathological and does not bring happiness to either party involved. By way of further reducing the fatigue produced by persons of the "selfish" type, these people should try to see the unfairness of their behavior and then find contentment in taking a little and in giving a little. The happiness of the other will be ample reward.

The opposite type of person to the over-energetic and enthusiastic type is also often found to be fatiguing. He is lethargic and apathetic and has to be "stirred up" to take

interest in any enterprise or conversational topic. His very lethargy makes heavy demands upon one's social resourcefulness and physical energy. A conflict is set up between one's sociability and one's own desire to be stimulated.

The person most likely to be made tired by the above described individual is one who is lacking in energy and initiative himself, but not quite to the same extent. If each tries to help the other fellow and at least to be responsive, the situation will improve. That delightful asset, social affability, will develop, and each will gain in confidence and will gradually become less fatigued or fatiguing. It might be well to draw attention here to the fact that those who passively accept services and those who are lacking in zealous energy are not on the whole so tiring as those of the giving and the over-enthusiastic types. The latter types of people inhibit our actions and thereby increase the intensity of our mental conflicts, whereas the former draw out our energies and give us some means of self-expression.

The nervous and emotionally excitable person we may also find to be tiring. This nervousness may take the form of fidgeting, fearful apprehension, peevish irritability, suspiciousness, hectic excitement and laughter, giggling, or melancholy and worry. These may be looked upon as emotional manifestations which are capable of arousing the corresponding emotions within ourselves by sympathetic induction. A mental conflict immediately results, on the one side being ranged our tabooed impulses and primitive emotions and on the other side our acquired social habits of serenity, equanimity, and cheerfulness even under adverse conditions. The feud is of long standing and always fatigue producing, but it becomes all the more tiring when the enemy's ranks are reinforced—by traitors as it were—by undesirable emotions induced in us through the very social medium of sympathy. Normally we look to social contact to draw out our finer rather than our feebler selves.

We shall be most affected by the nervous individual if we are of similar type ourselves and if we are still in the initial stages of the struggle to socialize our original, non-social instincts and emotions. We may be able to prevent the fatigue resulting from an intensified conflict by being forewarned

and aware of the true nature of the situation. We can then prevent ourselves from imitating the other's behavior and thereby inducing further emotion within ourselves, and we can direct our attention to helping the other person instead of concentrating upon and increasing our own worries. We can consciously draw attention to steadying and pleasing thoughts or scenes and so induce an atmosphere of reasonable optimism in place of hysterical excitement or anxiety.

Another type of person who is extremely fatiguing is the one who has developed a "grudge" against humanity or against any one who is superior to him in some particular. He is the possessor of what Adler terms an "inferiority complex".[1] He defends himself against his inferiority, real or supposed, and attempts to gain superiority in many subtle ways. One way is to "take it out" on the person with greater ability than himself, by thwarting him, dampening his ardor, belittling his achievements and his purpose, or by ridiculing him. This is another instance of Adler's "derogatory impulse". The victim is obliged to defend himself against this undermining of his stronghold and to "bolster up" his own courage. A conflict is set up in him between his faith in his own powers and his belief in the cause, on the one hand, and his fear of ridicule and disapproval on the other.

The people made most tired by the kind of person just described are those who lack self-confidence and who are very susceptible to the opinions and criticisms of others. They are usually more particularly suggestible to those whom they regard with deep affection. In order not to be fatigued by the dampening kind of individual, they would need to know the cause of the critical attitude and to learn to discount the remarks accordingly. They should also endeavor to become increasingly familiar with their own capabilities and disabilities by means of comparison, so as to get a stable foundation for confidence in themselves. The person with the "inferiority complex", at the same time, should become aware of his antisocial behavior and its true causes. He should find out his assets as well as his liabilities and should develop his natural

[1] A. Adler, *op. cit.*, see note 1, page 93.

gifts so as to give him the satisfaction he needs in a more desirable way.

Snobs form another class of tiring people. I refer here not only to the social snobs, but to those who, keenly aware of their own superiority in any field, whether social, financial, physical, or intellectual, lord it over others, making them conscious of their inferiority. It is probably a form of bullying and an expression of the instinct of self-assertion. There are the social snobs whose behavior tends to make one feel commonplace and cheap, the financial snobs who make one feel poverty-striken and dowdy, the physical snobs who make one feel feeble, awkward, and unlovely, but perhaps most tiring of all are the intellectual snobs. They make one feel stupid, unable to do anything and unable to learn. Their voiced or implied criticisms "cut us to the quick". We feel that we can never achieve anything—it is no use trying. Our minds become "blank" in their presence and we cannot even do our little best. In the presence of any kind of snob, a conflict is set up within us between our tendency toward self-expression and display and our fear of ridicule and criticism. Our normal outlets for emotional activity are blocked and physiological disturbances result which produce fatigue.

The people most likely to be affected in this way by snobs are those who already possess some inferiority feeling. As has already been suggested, they would need to find out and develop their individual assets, to give them the necessary opportunity for self-display. Some of them would need to reconsider their social values and learn the relative importance of such things as jewels, fine clothes, large houses, pretty faces, hard muscles, and spectacular intellectual feats. The snobs themselves should try to socialize their bullying tendencies. Moreover, they should study further the cause of their snobbishness. They will probably find that, although superior in some things, they are quite inferior in others, and that their endeavor to impress their particular superiority upon other people is itself an attempt to cover up some conscious or unconscious disability. They should learn to accept themselves as they really are.

There is a type of person who produces fatigue just by being very stimulating sexually. This is more common in

women than in men, though it may occur in either sex. The whole appearance, manner, and gait of the person may be erotically stimulating. It is all the more potent if unconscious, as it often is in young women who "are not supposed to think of such things", and who are therefore the sport of their unconscious impulses. Any person to whom such a woman may address herself is consciously or unconsciously set on his guard. Sex manifestations are tabooed by society, and so a mental conflict arises between the primitive sex impulses which have been stimulated and social habits of sexually indifferent behavior.

The person to whom a woman of this type would be fatiguing is one with strong erotic tendencies himself who has not developed to any extent the normal social outlets for the sex instinct. It is even possible that a woman of erotic appearance may be fatiguing to another member of her own sex if the latter has not outgrown her "homosexual" tendency—that is, the phase of "crushes" on girls. The fatigued person should become conscious of the situation and take steps to find the necessary sexual outlet in athletics and outdoor activity, dancing, and theaters. It would be well also if the person who exhibits strong erotic manifestations were to become conscious of this fact. The erotic behavior tendencies could then be curbed and expressed in a socially more approved way. Young women of this type would then be provided with the most valuable means of protection and thus be preserved to some extent from one of the dangers of their sex.

The apparent reverse of this situation may also be fatiguing, especially to any one with strong erotic tendencies. That is, the person who has built up a system of defenses, in the form of prudishness, false modesty, and pious demeanor, against an innately strong sex instinct may make others feel tired in his presence. His very defense mechanism calls attention to sex matters on the part of his associates and sets up in them a conflict between these desires and the desire to be approved and to appear "proper".

The remedy already suggested for the fatigued person in the presence of one sexually stimulating will apply in the above case also. The one who has developed the defense mechanism should equally become cognizant of this fact. He

should then endeavor to modify his extreme behavior and express his instincts along more normal and desirable lines.

A situation that is fatigue-producing may arise between two close friends, one of them apparently tending to produce a state of fatigue in the other. In reality, the tired person, while being very fond of his friend, half consciously perceives or thinks he perceives certain qualities in the friend which he very much dislikes. A conflict is set up between his affection for the friend and his disgust or dislike for these particular characteristics, real or supposed.

The thing for him to do in that case is to find out first whether his interpretations and surmises are correct—that is, whether or not the friend actually possesses the disapproved qualities. If he does not, then the conflict may disappear and the fatigue with it. If he does possess these qualities, then an adjustment must be effected in one of two ways. The qualities themselves must be reconsidered and reëvaluated, and the causes of their manifestation in the friend must be found and sympathetically understood. It may then be possible to accept the friend and the qualities after changing the attitude of disgust toward them, or it may be possible to accept the friend with a tangible hope that the qualities will be changed. If neither of these is possible, then the relative importance of the friendship and of adherence to certain principles involved in accepting a friend with the tabooed qualities must be considered. As a result, the friendship may have to go, if the principles count most; or the friendship may still remain and the qualities be tolerated as being of minor importance.

There is yet another situation in which fatigue is produced by a person, and that is when the latter possesses characteristics that other people find disagreeable. These may be antisocial and universally unpleasant, or they may be characteristics or mannerisms particularly disliked by the person who becomes tired in the presence of their possessor. A common instance is when the friend of a special pal of ours annoys us and makes us feel tired. It is probably with regard to this particular type of situation that the colloquial expression, "She makes me tired"—meaning, "She annoys me"—came into being. A conflict is set up between the desire

to express impatience or even anger and the wish to get away, on the one hand, and the desire to be socially agreeable or to please one's friend on the other.

We should be less tired if we were thoroughly aware of the total situation and could see the things that annoy us in their true perspective. We should be more sympathetic and able to tolerate the undesirable elements for the sake of the more pleasing aspects of the situation. Everybody should, moreover, search himself for socially offensive behavior and should try to conduct himself with as much grace and consideration for other people as possible.

In all the foregoing instances it would seem, then, that a very real cause of the fatigue produced in one person by another is the mental conflict aroused in the former by the latter's presence or his behavior. For the person who feels tired, the thing to do is to find out the nature of that conflict and endeavor to solve it, perhaps in the ways here suggested. It is for every one to find out for himself whether he induces fatigue in other people and whether he possesses antisocial or disagreeable character traits. He will find his happiness and that of his associates greatly increased if he removes or modifies these traits. Especially should the schoolteacher make a study of his or her personality and its effect upon the pupils, so that necessary changes can be made before serious results ensue. The changes may need to be made in the pupil's attitude or in the teacher's. The extent to which the personality of the teacher determines the healthy or the morbid and delinquent behavior of the child is becoming more and more generally recognized. The teacher who possesses a fatigue-inducing personality is a grave menace.

PSYCHIATRIC PHASES IN VOCATIONAL GUIDANCE*

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NOT SO many days ago a boy of fourteen confessed to me, with tears in his eyes, that it was no cinch to act like a roughneck all the time. He had been referred to the clinic as an incorrigible, running away from home and acting in such disorderly fashion at school that he could not be kept there longer and had been transferred to the Thomas Edison School, the Cleveland school for problem boys. There he apparently adjusted well because, as he claimed, he liked to be with the roughnecks. Investigation showed that he had been brought up by a mother who had separated from her husband and who, in the absence of her normal love object, showered all her affection upon the boy. She petted and pampered and coddled him so that as he grew older he became utterly unfit to cope with the other children in their rough-and-tumble sports and fighting. He soon recognized this timidity and underlying feeling of inadequacy and began to bend his energies to prove, ostensibly to others, but in reality mainly to himself, that he was no coward or "sissy". Hence he embarked upon a career of being a roughneck and a tough and soon satisfied the most experienced of those with whom he came into contact that he was, in truth, an incorrigible. Yet, as a matter of fact, when away from an environment in which he felt it necessary to misbehave and with a sympathetic listener to talk to, the patient was pathetically eager to discuss his essential timidities and admitted frankly that he was not really happy in his rôle of "roughneck".

What is to be done with a boy like this? What does the future hold for him? His own solution is significant. He hopes to join the navy as soon as possible. As a successful

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method of getting him accustomed to hard knocks and of actually proving to himself that he can fill a man's rôle, service in the navy may have considerable value. It will offer one element that is of great importance in adjusting the job to the man—namely, it will afford compensations for his feelings of inferiority.

Dr. R. P. Truitt, Director of the Division on the Prevention of Delinquency of The National Committee for Mental Hygiene, in a paper read before a group of vocational-guidance workers in Philadelphia, made this statement: "One of the determining influences in the selection of a vocation is and should be the need of compensating for inferiorities." I agree with Dr. Truitt in his statement that a job must necessarily have compensations for feelings of inferiority and I should like to amplify this statement by pointing out the fact that these job compensations need not be specific, but may be part of a general adult adjustment which must satisfy feelings of inferiority developed in childhood. An effort will be made in this paper to point out that vocational guidance must take into account not only the intellectual capacities of the individual, but also his emotional or affective life. And the phase of the affective life that I will stress will be the emotional reactions to feelings of inadequacy—commonly called the inferiority complex.

Feelings of inferiority, insufficiency, insecurity, and the like have been used perhaps too frequently to explain various types of behavior, but they do express succinctly recognition that the world is after all bigger than we are and that life is at best an uphill struggle. Every one has his or her inferiority or, to phrase it popularly, his or her handicaps or limitations. Sometimes they seem quite trivial, as in the case of the girl who feels that her attractiveness would be more complete with hair of a different color; sometimes they are of a much more serious nature. They may concern some physical defect, either real or fancied, or they may arise from some earlier situation in the patient's life. It is not the actual inferiority that determines the patient's behavior; it is his reaction to it that decides whether or not it will unduly influence his behavior. He may face it squarely and compensate for it successfully, as is so often the case with the physical weakling

who, by dint of extra effort, comes to be of more than average strength and endurance. Or he may reject his inferiority entirely, as in the case just mentioned, where the boy, by going to the opposite extreme in behavior—or, as it is generally called, by overcompensating—managed to appear like some one very different from his true self. Or finally the individual may succumb to his inferiorities—feel that the difficulties are insurmountable and that further effort is useless. These children are apt to become discouraged, irritable, prone to feel that others are imposing upon them. By either overcompensating or succumbing, the child tends to evade reality and by just the degree to which he does that does he make successful life adjustment difficult. A frank facing and acceptance of an inferiority or the adoption of an evasive type of reaction depends not so much upon the handicaps themselves as it does upon the total life adjustment of the individual.

In the following case, the difficulties came not from the boy's physical defect, but from its effect on his entire personality. Tony, a fifteen-year-old youngster of foreign parents, was referred to the clinic because of his insolence and his refusal to comply with school requirements either as to discipline or lessons. Four years ago he had been the victim of an explosion which had all but blinded him, and from that time on he had been a changed person. Formerly sunny and likable, he turned into a sullen, morose, irritable youngster who resented every advance made to him. The efforts of the sight-saving classes in which he was placed were largely nullified by his unwillingness frankly to admit that he really needed the type of training that his poor vision made necessary.

At home, the same change was noticeable. As the first boy, much had been expected of Tony and up to the time of the accident, he had given every promise of fulfilling these expectations. After the accident, a brother, immediately younger than the patient, assumed his place in the family life, and the family apparently adopted the attitude that Tony was no longer of much account, that little further could be expected from him. In talking to the boy, it was evident that the thing that hurt most was not the visual condition, but the fact that his family acted as if he would be a burden on them

for all time. It is not surprising that profound feelings of inferiority developed in the patient and that he resented all efforts to direct him, since he interpreted these efforts as attempts to impress him further with his inferiority. Neither is it surprising that the sight-saving classes were not inviting since they served as a constant reminder of his own deficiencies. Vocational training with this boy is more or less at a standstill. It will remain so until the family can be induced to change their attitude, or the patient can be made to understand that in many ways he is as good or perhaps better than the rest, and that, after all, he is not really doomed to be set aside in life as he has been in his family.

Fortunately for the treatment in this case, the patient has recently uncovered in himself a rather marked musical trend and is now deriving considerable satisfaction from playing on his mouth organ and mastering the intricacies of a saxophone. It is hoped that Tony will find in his music a success and satisfaction that will enhance him in the eyes of himself and family. If he develops sufficient skill to join an orchestra and thereby become self-supporting, he is well on the road to adjustment, since by so doing he will demonstrate that he is capable of taking care of himself. The compensations in this job come not so much from the intrinsic nature of the job, but from the fact that it assures the boy that he is not a total loss to himself and others.

Again a fancied physical inferiority had a far-reaching influence on a nine-year-old youngster whom the school referred with the complaint that punishment and discipline were totally ineffective. For nine months of his second year, Joe had suffered a left-side facial paralysis of unknown origin. This had apparently left no residual. During the illness, however, a picture of the patient was taken. This hung in a conspicuous place near the family mirror. Conversation with Joe at the clinic went about as follows:

"What happens at school, Joe?"

"The kids, they make me mad."

"What do they do?"

"They always make faces at me."

"Why?"

"I don't know."

"Do you make faces at them?"
"No."
"Do you need to?"
Silence, then a muttered, "No."
"Do you have a funny face already?"
"Yes."
"Do you think they imitate you?"
"Yes."
"What do you do?"
"I get mad and hit them. They're always making funny faces at me."

Then came out the story that every time Joe combed his hair, he saw the picture of himself hanging by the mirror and that he always thought to himself that he had "a funny face". At school, the children soon learned that to make funny faces at Joe was like waving a red flag before a bull. And Joe acted just like a bull in school because he would hit any youngster who mocked him and nothing the teacher could do sufficed to stop him. No wonder the teachers felt him to be without fear of punishment. Six or seven years later, if referred for vocational guidance, Joe would have been a real problem, because he would have built up a set of behavior patterns very difficult to alter. Now the possibilities of helping him to a better adjustment seem far more hopeful, a bit of prevention that should measurably lighten the task of those who subsequently must help him in his life adaptations.

Actual intellectual incapacities may also be a focus around which feelings of inferiority may arise. One may comment, however, that this development is to be expected in every retarded individual and yet, as a rule, such individuals learn to conform reasonably to social requirements. This is quite true, and when one finds one of the less gifted youngsters misbehaving, it is not enough to say merely that he or she is feebleminded. Take the case of seventeen-year-old Sally, who came to the clinic with a record of stealing. In early childhood, following a long illness during which she received an undue share of her mother's care and attention, a change in disposition had been noted. She became fretful, petulant, rather demanding, feeling that she did not get the considera-

tion due her, her actions tending to estrange her from the family. Aided by a kindly school system, she did manage to graduate from an elementary school at sixteen, but for many years she had recognized that her sisters, all of whom were younger, were of distinctly good intellectual attainments and quite able to surpass her record. She came to feel herself the "ugly duckling" and developed a vivid fantasy life which, a year before she was referred to the clinic, led to her running away to find the place of her dreams.

She was apprehended and taken to the Detention Home instead. There her mental age was found to be about ten years, giving her an I.Q. in the sixties. She was paroled and, following the suggestion that she do unskilled labor, housework was found for her, despite her objection that ever since she could remember she had been helping her mother do the housework at home. However, she was informed that that was what she was good for, and for a year and a half she had been shifting around, hopeless, dissatisfied, and with little or no encouragement from home or anywhere else. Finally she began stealing systematically from her employer, spending part of the money on herself, but adding two dollars to her weekly wage which she turned over to her mother with the pathetic statement that her work had been so satisfactory that she had been granted this raise.

Surely this girl's feelings of inferiority and her unsuccessful efforts to compensate resulted not so much from her actual mental level as from her reaction to the situation in the home. Vocational guidance for Sally must take into consideration, in addition to her limited intelligence, her feelings toward her limitations. Recommending housework in this case violated the tenet that a job must in some way bring compensations for previous inferiorities. The patient had been made more or less of a kitchen slave at home, had developed a profound distaste for the work, and resented the implication that she was fitted for nothing else. That she became restless and unhappy and indulged in stealing to gain some of the satisfactions of having money with which to splurge, as well as to make a good showing to her mother, is not a surprising outcome.

The influence of the home in the production of marked

inferiorities is noticeable in many of our cases. William, a boy of sixteen, with average intelligence, is a good example of this group. After spending the first eleven years of his life in various institutions because his parents had separated shortly after his birth, the boy came to live with a maiden aunt who had marked prejudices and strict standards of behavior. Quite untrained in the niceties of society, the boy naturally failed to respond promptly to her efforts to instruct him and soon she began to feel him uncoöperative, to nag him, and to call him ungrateful for her kindness in letting him come to her home. In addition, there was in the home another nephew, Walter, whose mother had died at his birth. The aunt had raised this boy from infancy, felt that she had done a good job of it, and continually held him up before the patient as a model. Unfortunately for William, Walter, who was of the same age, not only showed the results of his earlier training, but proved to be superior physically and mentally. With this unfavorable comparison constantly before him and the aunt's open preferences for the other boy, William soon came to consider himself of little account. He became "touchy", felt that the others were trying to impose upon him, and, as he grew into adolescence and realized his increasing strength, began actively to resent any efforts to control him. Finally he hit back at his aunt, causing her to bring him to the juvenile court, which in turn referred him to the clinic. We felt that if the pressures at home were lessened and a satisfactory job found for the patient, many of his personality faults would disappear.

At first our plan seemed crowned with success, but soon there was a slump. The patient, in a fit of anger, had thrown up his job and things at home were as unsatisfactory as ever. Further investigation showed that the aunt had returned to her nagging, querulous ways. It was also learned that she was suffering from high blood pressure and Bright's disease, sufficient explanation, probably, of her irritability and lack of self-control. It does not seem likely that the patient will do well in work until the home difficulties are straightened out or he is removed from their influence.

In most of the cases mentioned, there has been a noticeable absence of elements in the patient's previous life that could

bring the satisfactions of success. The children necessarily view the future with foreboding because they fear it will overwhelm them. The compensation for inferiorities found in so many jobs lies very often in the fact that the boy or girl feels that he or she is now playing an adult rôle in life and is doing it successfully. This is satisfying and has a steadying influence. In quoting Dr. Truitt earlier in the paper, that work always must have some compensatory value for some inferiority, I pointed out that the compensation in the job need not be specific for defects or disabilities of the individual who is to make an adequate adult adjustment. Other factors may enter the individual's life and compensate for feelings of inferiority which have been interfering with proper vocational success. The following case illustrates this point:

Sam was referred to the clinic because he stole library books. Further investigation soon revealed that the problem was a question of personality difficulties, since others considered the patient a great liar and boaster and not to be depended upon to do anything requested of him. Sam was almost eighteen at the time of his coming to the clinic, and since he had received his work permit at sixteen, had engaged in almost every line of activity possible, always throwing up his jobs in periods of anger over some real or fancied slight on the part of his employer or associates. In studying the boy, the following handicaps or limitations were noted: he was somewhat nearsighted and slightly deaf, and was found to possess a mental age of a little less than thirteen years on the Stanford-Binet test, giving him an intelligence quotient in the lower eighties. Furthermore the financial circumstances of the parents had been at all times either marginal or dependent, and the patient had received one hard knock after another as a result of his parents' precarious situation.

Earlier Sam had found it difficult to mingle freely with boys, but within the past two or three years he had gotten in with a gang with rather marked delinquent tendencies and it was under the influence of one of them that he had become involved in the theft. For many years, under the drive of his inadequacy feelings, the boy had boasted of his athletic prowess, of his ability to do various things, and it

was undoubtedly their tales of derring-do that lured him to the gang.

Treatment had to be directed toward establishing in the patient a degree of self-respect that would counteract the feelings of inferiority developed in his previous life. About six months before his coming to the clinic, the patient's parents had died, and he had gone to live with some distant relatives. They were seen, the boy's plight was explained to them, and they were induced to take a real interest in him and to make him feel that he was one of the family. To this the boy reacted by saying that it was the first real home he had ever known. Then, through the influence of a friend of the clinic's, Sam was invited to join a desirable club in one of the recreational centers, a fact that pleased the boy tremendously, especially as he believed that it was a spontaneous act on the part of the club. Two weeks after he had been to the clinic, he threw up one job and within a period of five weeks quit two more in moments of anger. By that time the plans outlined began to be effective, the boy showed a definite response, and then for the first time he found a job that he really liked. He is now an apprentice in a trade, a job apparently no more satisfactory or interesting than many of the others he had previously held. He has held it for a period of over five months with no waning in his enthusiasm. The change in his work record seems in keeping with the generally more satisfactory adjustment of the patient. Under the influence of more kindly surroundings, in which he obtains acceptable satisfactions, Sam has genuinely expanded and, while he still likes to tell dramatic stories about himself, he is far from the blatant, self-assertive fellow he was formerly.

It is doubtful whether it would have been possible to secure for Sam a job that could really have met the demands of his inner strivings. There are too many so-called "blind-alley" jobs, and Sam was not sufficiently gifted to work himself out of one of these. Yet he is now sticking industriously at his job of learning a trade and gives promise of settling down into a fairly dependable sort of person.

Psychiatry concerns itself with the total integration of the personality, including thus the individual physical and mental make-up. Theoretically it includes equal consideration of all

phases of life, but practically it does and should limit itself largely to an attempt to understand the fundamental motivations of human conduct. In other words, it has as its goal knowledge of the emotional life, the term emotional being used in its broadest sense and being considered in contrast to the intellectual. Only in recent years has psychiatry devoted much attention to the study of the emotional life, for which change in direction the labors of dynamic psychiatry have been largely accountable. In other fields, the change in stress is also being felt. As a result of the World War and the opportunity granted for studying a large group of men, our standards of the level of human intelligence were materially lowered and with that drop went the explanation of much of the delinquency that comes before the courts. Recent observers from Massachusetts and Illinois have stated that the levels of intelligence in the prison and outside are about on a par. Now the point of emphasis has shifted to embrace the recognition of emotional factors in the causation of delinquent trends.

So, too, in the school. Progressive education, with its informal curriculum, aims directly at the personality adjustment of the boy or girl in the belief that intellectual growth will then proceed naturally. Many of the innovations in the older and larger systems, including vocational education, work for the emotional adjustment of many children by offering something in which they for the first time find themselves successful. Similarly in social work, the need for a more complete understanding of the individual is superseding the old idea of the social worker as a detective whose job it was to ascertain the person's fitness for relief. And in the same way, vocational guidance needs to consider the entire life adjustment of the individual.

In this paper only one phase of the emotional life has been discussed—namely, the phase that centers around the feelings of inferiority and inadequacy which form a part of the individual's motivations. An effort has been made to show that in vocational guidance these feelings must be regarded and that the compensations for them may take two forms. In the first place, the individual may find compensations in the job itself, as in the case of the boy who wants to join the navy;

or, in the second place, the job may bring really few compensations, but the individual may find them elsewhere, as did Sam in the last case mentioned. In view of the large proportion of blind-alley jobs that must necessarily be filled, I suspect that the latter type of adjustment is the one most frequently made. As a matter of fact, I imagine it is the adjustment elsewhere than in the vocational field which accounts for the fact that so many men "marry and settle down".

REPORT ON THE NINTH INTERNATIONAL PRISON CONGRESS

LONDON, AUGUST 3–10, 1925 *

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AMONG the many stimulating and challenging impressions which every one who attended the recent International Prison Congress must have carried away with him, two stand out above all others in their interest and significance.

First there is the truly international character of the congress. The significance of this portentous achievement of bringing together representatives of fifty-three countries for the free discussion of a problem that, in spite of its local characteristics, goes beyond all questions of nationality cannot be overestimated. All those artificial lines of friction and obstacles to free human intercourse which came with the World War and after seemed to have entirely vanished for the moment, and we experienced a renewal of hope in human nature as we daily watched the respectful attention which the audience gave alike to foe and friend of but a few years ago. In this connection the rare tact and broad humanitarianism of the presiding officers of the general and the various section meetings deserve particular mention.

The other outstanding impression relates to the genuine earnestness with which the participants in this congress went about their respective tasks. One missed entirely here that impression of levity and superficiality which characterizes many of our own gatherings, conducted as they often seem to be rather in the spirit of holiday-making than in that of science. Not that this congress lacked in provision for the entertainment of the delegates, a matter to which our British hosts attended with great magnanimity. But the temper and

* The comments and opinions expressed in this report are entirely personal, Dr. Glueck attended the Congress as one of the New York State delegates and as a representative of the Joint Committee on Methods of Preventing Delinquency.

profoundly learned background of those who gave its deliberations leadership and direction was one of the most stimulating experiences of a lifetime.

Moreover, it seems to the writer that this congress ought to slay once for all the familiar ghost of the supposed incompatibility between the thinking of those who represent the penal law and those whose main concern is with the nature of man and with the problem of the direction of human desire and action. We listened here to thunderings from intellectual giants from both these fields, and if, as is evident from the resolutions finally adopted by the congress, the purely philosophical doctrinaires gave way decidedly to a scientific humanitarianism in both the theoretical and the practical aspects of the problems of crime, it was an outcome only to be expected from a free interchange of views between the two camps.

The orderliness and dispatch and almost entire absence of confusion with which the business of the congress was conducted was due to the rare genius of Professor Van der Aa, its secretary general, who had so much to do with the crystallization of its aims and deliberations into tangible and workable agenda.

The congress, in its range of discussion, was divided into three general sections, dealing, respectively, with legislation, administration, and prevention, with a number of specific questions under each.

These questions were submitted to a number of outstanding persons throughout the various member countries who were thought to be in a position to offer intelligent and expert opinion on the questions propounded. The replies were then summarized by a "*rapporteur*", chosen for each question, who added his own comment upon the opinions expressed. These final summaries of opinion were presented for discussion in the respective sections, and in turn became crystallized in each section into appropriate resolutions.

These resolutions were then presented to the general assembly for final disposition, again after being subjected to critical discussion by the general assembly. In addition to these strictly defined deliberations, four addresses were delivered at the general assemblies, as follows: *The Principles*

of Punishment, by the Right Honorable Earl of Oxford and Asquith, K.G.; *Alternatives to Imprisonment,* by the Right Honorable Lord Hewart, Lord Chief Justice of England; *The Indeterminate Sentence,* by the Right Honorable Viscount Cave, Lord Chancellor; and *The Meaning of Punishment,* by the Right Honorable Viscount Haldane of Cloan, K.T., O.M. These important contributions, by four of the outstanding men of England to-day, should be read in their entirety for a full appreciation of the attitude of England toward these problems.

In the writer's opinion, Viscount Haldane's address, *The Meaning of Punishment,* particularly deserves the careful attention of every one interested in prison reform. The philosophical challenge of the idea of the total abolition of punishment which his paper so learnedly presents constitutes not only a vital contribution to the problem of crime and punishment, but touches upon some of the most fundamental questions raised by the more recent psychological definition of the nature of conscience.

I. Legislation

Section I, on legislation, dealt with the following questions:

1. "Should the authority charged with the duty of public prosecution have a free discretion whether proceedings should be taken or not in any case? If so, should such discretion be subject to restraint within certain limits and to control? Should not the court also have a discretion whether or not to record a conviction, although the facts are practically proved?"

This question was handled under the very able leadership of Professor M. Liepman, Director of Criminal Law, Hamburg, Germany. As might have been expected, the discussion of this topic was very spirited, since there was difficulty in making it entirely clear that what seemed to be primarily a challenge to the traditional rights of the prosecuting authorities had come to assume a much broader significance in the light of the principle, which is rapidly gaining ground, that the state should concern itself primarily with the offender and not with the offense. The question was originally submitted to a number of the world's prominent penal philosophers, as

well as to penal administrators, and the replies offered by them should be read in detail. It is to be regretted that the American point of view was not presented in the discussion of this important question, particularly in view of the significantly political character of the prosecuting attorney's office in this country. Moreover, in connection with this question, an opportunity might have been found to stimulate an intelligent discussion of the significant challenge involved in the conception (strictly American, as far as I know) of the public defender. The resolutions finally adopted with respect to this question were as follows:

> "Having regard to the general tendency of the evolution of the penal law, a wide application of the principle of opportunity is recommended in all cases where the general interest would be better served by suppressing proceedings.
>
> "For offenses against police regulations and offenses committed by minors the principle of deciding whether proceedings should be suppressed or not for reasons of opportunity ought to be very broadly applied.
>
> "The exercise of such suppression should be subject to a control. At the same time, having regard to the diversity of judicial organization in the different countries, it is not possible in an international congress to specify the kind of control which should be exercised, notably by the judicial authorities, or by allowing the public to prosecute."

2. The second question in the section on legislation was, "What measures could be taken instead of imprisonment, with regard to offenders who have committed a petty offense or an offense which does not constitute a danger to public security?"

It is regrettable that in connection with this question, too, touching as it does upon the uniquely American idea of probation, the voice of the American delegation was barely heard. It is true that Mr. James P. Ramsay, the veteran probation officer, and author of *One More Chance,* spoke during the discussion of the subject. But there was missed here a good opportunity to put before the congress a well-organized and well-thought-out statement of what the real meaning and philosophy of the American notion of probation is, since, as developed in connection with the discussion of the individualization of punishment and of the question of the indeterminate sentence, there still seems to be a good deal of misunderstanding on this subject by our foreign colleagues.

A presentation of this sort might also have influenced the

speech of the Lord Chancellor, to which I shall refer later. Nevertheless, after a good deal of discussion, the following resolutions were adopted:

> "This section hopes that every endeavor will be made to substitute in suitable cases other awards in place of imprisonment. They suggest in particular that:
>
> "a. The system of probation should be extended to the utmost extent.
>
> "b. The power of court to impose fines should be extended and the machinery for payment of fines should be developed so as to eliminate as far as possible imprisonment in default of payment."

The discussion of this question brought to light unmistakably the general consensus of opinion as to the futility and actual evil of short sentences, since without any possible capacity for doing the prisoner any good, they at the same time tend to break down such deterrent influence as the fear of the unknown experience of imprisonment may have had, at least upon certain classes of the population.

The English particularly attribute a good deal of the reduction of their prison population to their rather extensive system of fining. They are not, however, so sanguine about probation.

3. The third question of this section was, "Would it be possible, and within what limits, to apply the principle of the indeterminate sentence in the struggle against recidivism, not only as far as grave offenses are concerned, but also for any other case?"

As was to be expected, this question provoked the most intense and spirited discussion, since from the replies originally received to it and from the summary of the *rapporteur*—Mr. Broderick, Recorder of Bournemouth, and a member of the advisory committee at Camp Hill Prevention Prison (the English camp for alleged confirmed criminals)—the question might be easily assumed to be a direct challenge to the traditional authority of the court to determine the sentence in the individual case. In this connection it is interesting to quote from the reply of Major Lawes, Warden of Sing Sing Prison, who says, among other things:

"How long it will take to cure the offender is not for the court. In a prison fitted for the purposes of classification there will be a necessary period of observation. There will be a

complete mental and physical examination; past history, heredity, and so forth, will be taken into consideration. It can then be determined how long it will take to restore him to a condition fit to reënter society, or whether there is no hope of rehabilitation. When released on parole, he will still be liable to recall."

Naturally, the splendid array of penal philosophers and jurists which the continent of Europe sent to the congress fought tooth and nail against this, to their minds, wholly anarchical proposition of leaving to some one other than the court the determination of what they insisted upon calling the punishment. There was a decided failure on the part of many to grasp the scientific humanitarianism which lies back of the idea of the indeterminate sentence, as we conceive of it in America. On the other hand, those of the delegates, particularly some of those from the Latin countries, who supported the idea—as, for instance, Professor Ferri of Rome—persisted in keeping in the foreground the promise of greater social security which the idea contains and only incidentally the greater opportunity for the reconstruction of the individual offender. That the promise of greater social security ultimately lies in the prevention of crime and in the cure of those who have become habituated to criminal ways is a notion that apparently requires a great deal more emphasis.

If the foregoing brief remarks contain an adverse criticism of the general European attitude toward the question of the indeterminate sentence, the German and Belgian delegates must be excluded from this criticism, since they did valiant work in assisting the American delegation in shaping the terms of the resolutions that were finally adopted.

Of course, the American delegates, in championing those ideas of progressive prison administration and penal legislation which are more or less of American origin, had to face what seemed to be just criticism, especially from our English confrères, as to the results of these presumably progressive measures. The American criminal situation, they said, is notoriously bad, perhaps worse than it is in any other country, and while England can show a truly enviable record of reduction of prison population and of the closing down of prisons for lack of use for them, we in America are still engaged in an

extensive program of new-prison construction, and crime is more rampant than ever. It would take one altogether beyond the scope of this report to enter into a detailed consideration of the reasons for this, but since the Lord Chancellor's speech, by implication at least, suggested an attempt to connect our experimentation in these matters with our notoriously bad criminal situation, a few remarks should be made on this subject.

In the writer's opinion—and he believes that this opinion is shared by other students of the question—any attempt to attribute our bad criminal situation to the introduction of such progressive measures as the scientific study of the offender, probation, and the indeterminate sentence, and the definite purpose of looking to reformation as the greatest promise of social security, must be regarded as exceedingly unfair. Its unfairness and inaccuracy should be stressed more frequently than has been the case heretofore, because, to an increasing degree the reactionaries in our country resort to a criticism of these measures whenever a new wave of hysterical criminal terror spreads over the land.

There are other, more obvious, though less pleasant causes for our bad criminal situation which should be pointed out, especially when a comparison is attempted between our criminal situation and that of Great Britain. In the first place, no other country has to cope with so great a diversity of population as ours. Even simple prison regulations have to be given in several languages if they are to be understood by all the prisoners. And when it comes to the question of an appeal to a certain ideal of ethics, we have no traditions, no ingrained memory patterns, to which all of our population or even a large majority of it can respond in any sort of uniform fashion. One only has to observe how uniformly the English people are stirred and thrilled by a newspaper notice of an important event in the life of the royal family to realize why they are able to get so much greater responsiveness to their efforts in dealing with the problem of crime than we are with our multi-colored social traditions.

Then, again, if we are honest in speaking of these matters, it must be admitted that our failure to cope with the problem of crime is only one aspect of our profound political inade-

quacy. Our administration of the problem of crime is infinitely better after the prisoner has passed through the police and judicial machinery than it is up to this point. The American criminal sooner or later becomes convinced, through his contact with our police and judicial system, that his chances of escaping the penalty for his crime are very good indeed. In fact he comes to feel, and to a large extent justifiably so, that it is largely the criminal who is quite helpless as regards money and political influence, or the inexperienced first offender and bungler, who runs the chance of detection and conviction. This is a very sad state of affairs indeed, and will be corrected only through a very fundamental change in our socio-political attitude towards the problem of crime.

But the failure to cope with this problem should not be attributed to those eminently sane and practical measures which would surely lead to an adequate handling of it if they were not counteracted by the vicious political characteristics of our police and judicial machinery. Let us not forget that after all these progressive measures which are being so constantly challenged have their chance only with a very minor portion of those who commit crime, since most of our crime remains undetected, and, when detected, a large portion of it never reaches the machinery of reconstruction of which we are speaking.

It would seem more correct to say that we in America do not suffer so much from the "criminal problem", so-called, as we do from a general lawlessness, bred on the one hand of our admittedly bad police and criminal-law administration, and, on the other hand, of a want in our population of an adequate and consciously entertained purpose to give preference to a socially decent and honest way of life. Unfortunately all classes of our society are tinged by this social inadequacy and immaturity.

The resolutions finally adopted in connection with this question, after much discussion and repeated postponement of final action, are unquestionably the best that could have been expected from an international congress. They are:

> "a. The section is of the opinion that the indeterminate sentence is the necessary consequence of the individualization of punishment and one of the most efficacious means of social defense.

"b. The laws of each country should determine whether and for what cases there should be a maximum duration of the indeterminate sentence. There should in every case be guarantees and rules of conditional release with executive adaptation suitable to national conditions."

4. The fourth question of Section I, closely related to the preceding one was, "What may be done to forward the judicious application of the principle of individualization of punishment by the judge who assigns the penalty to be inflicted on the offender?"

The resolutions finally adopted in this connection strike at the fundamental philosophy of all progressive thinkers in this field, and show to what extent a general consensus of opinion can be reached in these matters when adequate opportunity is given for the free interchange of thought. They are as follows:

"Before imposing any sentence or penalty, it should be an essential condition in the criminal procedure of all countries that the judge should inform himself of all the material circumstances affecting the character, antecedents, conduct, and mode of life of the offender and also any other matters which may be necessary for the purpose of properly determining the appropriate sentence or penalty." And in practice,

"a. That penal law should give the judge a choice of penalties and similar measures for prevention and security and should not strictly limit his power. It should only lay down general directions and so leave the judge free to apply the principle of individualization.

"b. The courts should be specialized as far as possible and in particular the juvenile courts should be separate from those for adults.

"c. Judicial studies should be supplemented by criminological ones. All who wish to be magistrates should be compelled to attend lectures on psychology, sociology, forensic psychiatry, and penology.

"d. The judges should devote themselves solely and permanently to criminal law and there should be sufficient opportunity for advancement in this branch.

"e. Courses of lectures should be established to complete their knowledge of criminology. They should have a full knowledge of prisons and similar institutions and should visit them frequently.

"f. The judge, before determining the penalty, should have a full knowledge of the physical and the psychic conditions and the social life of the accused and the motives for the crime.

"g. For this purpose inquiries about all his circumstances should be made before the trial. These inquiries should not be made by the police, but should be those of the magistrate himself or of persons authorized by him for this purpose, whom he should have at his disposal.

"h. Penal law should give the judge the power of obtaining information from every one who knows anything about the personality of the defendant and of his social environment.

"i. If these means give no sufficient idea of the physical and psychic

condition of the defendant, the judge should be allowed to have him examined by physicians and psychologists.

"j. The trial ought to be divided into two parts: in the first the examination and decision as to his guilt should take place; in the second the punishment should be discussed and fixed. From this part the public and the injured party should be excluded."

To comment adequately upon the fundamental significance of these far-reaching resolutions requires a much broader opportunity than is afforded in the present report. Certainly, American students of criminology ought to see in these resolutions, which were unanimously adopted, a full vindication of all those efforts toward a socialization and humanization of the criminal law and of criminal procedure initiated principally by Dean Pound and carried on, in late years particularly, by the psychiatrists who have become interested in the problem of crime.

These resolutions might well be taken as the immediate and practical goal of the reform movement in this field and ought to furnish the much needed concrete guiding lines for the training of our future judges in our law schools. The writer intends to deal with this set of resolutions more adequately at some future time.

II. Administration.

Section II of the congress—that on administration—also dealt with four questions.

1. The first was, "If a system of some special form of detention be adopted as a means of repression with respect to certain recidivists, by what authority should such detention be procured, and in what manner should it be executed?"

The resolutions adopted in connection with this question were as follows:

"a. A system of special or preventive detention (preventive in the sense of social security) for habitual criminals is desirable for the protection of society.

"b. The special detention should be ordered by judicial authority.

"c. While the object of the detention is primarily preventive, reformative influence also should be exercised as far as possible.

"d. The conditions of such detention should be less rigorous than those of ordinary penal discipline."

As is well known, both the principle and the practice of the procedure reflected in this question and in the accompanying

resolutions are at present being given a trial in America and England. The discussion of the subject was more or less in accord with the prevalent American opinion that what is needed most in this connection is the establishment of better diagnostic criteria for the determination of the degree of fixity of the habituation to crime on the part of a given individual, and of methods for the institutional administration of these special institutions for recidivists. The experiences of the states of Massachusetts and New York ought to aid here materially.

2. The second question dealt with by this section was, "Is it desirable that services, *e.g.*, laboratories or clinics, should be installed in prisons for the scientific study of criminals?

"Would such a system help both to determine the causes of criminality and to suggest the suitable treatment in the case of the individual offender?

"Would it not be advisable to use the same system for the examination before trial of persons suspected of some mental defect?"

The resolutions adopted in connection with these questions might well be brought to the attention of those of our legislators who so persistently block progress in these directions through a refusal to provide the necessary funds. A shining example of this is of course furnished by the state of New York, where a magnificent and very expensive physical plant is lying idle for lack of the funds with which to put it into operation. The resolutions, which were carried by an overwhelming majority, were:

> "a. It is necessary that unconvicted and convicted offenders should be physically and mentally examined by specially qualified medical practitioners, and that the necessary services should be installed for this purpose in the institutions.
>
> "b. Such a system would help to determine the biological and sociological causes of criminality and to suggest the suitable treatment for the individual offender."

3. The third question was, "Is it advisable to apply a classification of prisoners, having regard to their character, the gravity of the punishment, or the nature of the offense, so as to admit the application of different and appropriate

régimes, and in what way should the penal establishments be arranged for this purpose?"

This question, as is well known, has been very much in the foreground of American criminology, and it is pleasant to record that in the discussion of it, the American delegates participated quite actively. The discussion led to the adoption of the following resolutions:

"a. That the prevention of the contamination of the less criminal prisoners by those more experienced in crime is one of the first essentials in prison treatment.

"b. That after the necessary divisions according to age and sex have been made and the mental status of the prisoner has been taken into account, classification should be according to character and ability to be reformed.

"c. That the shorter-term prisoners should be treated apart from those with longer sentences in order that a régime or course of training appropriate to the latter, but not possible with the former, may be applied.

"d. That the various classifications of the prisoners should be located separately, and where possible in different buildings, either in the same establishment under the one administrative head or, in certain cases, in special establishments.

"e. That it is difficult to apply the necessary individual treatment of prisoners where the number in any one establishment exceeds 500."

Perhaps no more extensive scheme for the classification of prisoners has been proposed than that which is implied, at any rate, in the reorganization plans of the New York state prison system.[1] This world-wide recognition of the inevitable dependence of adequate treatment upon proper classification, as regards housing and management of the different types of offenders, ought to be of assistance in getting the New York State Legislature to appropriate the necessary funds for putting this reorganization into effect.

4. The last question of the section on administration dealt with the matter of compensating prisoners for their work in prison. The resolutions adopted with reference to this were as follows:

"a. Though the state is under no obligation to pay for work compulsorily performed by prisoners, it is desirable that it should encourage them to work well by offering a recompense.

"b. Where this recompense takes the form of pecuniary payment, it should not be liable to seizure, nor (as a rule) should the prisoner be

[1] See *Concerning Prisoners*, by Bernard Glueck, M.D. MENTAL HYGIENE, Vol. 2, pp. 177–218, April, 1918.

allowed to dispose of it in making outside payments, except, perhaps, in the case of serious illness in his family where no gratuitous aid is procurable, or in the case of poverty of his family. The inviolability of this recompense does not extend to moneys brought in by the prisoner or acquired by him during his sentence from outside sources.

"c. It is desirable that the gratuity (whether augmented by reward for good work or not) should be utilized for the purpose of repaying the liabilities of the prisoner both to the state and to his victim, after reasonable provision has been made for wife and family.

"d. The prisoner on discharge should not be at liberty to deal with his gratuity as he chooses. It should be regarded as in the hands of trustees who will expend it for him as seems best in his real interest."

III. Prevention

On first glance the questions brought up for discussion in Section III, on prevention, might not appear to be especially well chosen. This seems to be the case particularly in connection with the amount of attention paid to the question of wayward childhood. But as the discussion proceeded, the scope of these questions broadened considerably and the resolutions adopted in connection with them are very far-reaching indeed.

1. The first question was, "What would be the most effective way to organize the control by the state, by associations, or by private persons over criminals conditionally convicted or conditionally discharged (on parole or license)?"

This question, of course, deals with the administration of the problem of probation and parole. Although considerable discussion took place, only one speaker, the Austrian delegate, a well-known woman social worker, discussed the subject in a manner that was in accord with the American idea of probation and parole. After the legal philosophers and the penologists had had their say, Miss Löhr, a trained social worker, succeeded in turning the discussion into more appropriate channels. She stressed the social-work character of the tasks of probation and parole supervision and justly called attention to the fact that it is the equipment of the personnel for these tasks that largely determines the success or failure of these measures. She also stressed the special character of these tasks when applied to children.

Nevertheless, the resolutions finally adopted fell considerably short of what might have been expected, and American practice, in certain communities at any rate, is decidedly in

advance of the theory reflected by them. The resolutions adopted were:

"a. That the section on prevention considers that the control of persons sentenced or released under conditions (conditionally) should not be exercised by the police.

"b. The organization might consist either in private societies financially supported and supervised by the state or in official or semi-official organizations, or persons paid by the state and placed at the disposal of the courts (without any connection with the police).

"c. For all persons released conditionally probation should be obligatory. Submission to supervision should be voluntary only when the sentence has been completed.

"d. The section is also of the opinion that international agreement should be fostered between the central societies of different countries to provide for released persons who go to a country other than that in which they were sentenced."

2. The second question of this section was, "Can more effective arrangements be made between different states in the struggle to protect themselves against international criminals?"

The resolutions adopted were as follows:

"a. The third section considers that the struggle against the criminal would be facilitated if different states could agree to allow direct communication between the judicial and police authorities of different countries with a view to the speedier arrest of offenders of certain specified classes, or the exchange of information with respect to dangerous criminals. Each state should appoint a central police authority authorized to communicate directly and without needless complications with the corresponding authorities in other states.

"b. As to the law of extradition, the time has not yet come to attempt the conclusion of a universal extradition treaty. The section considers that it is more desirable at present to draw up a draft treaty which might serve as a model for special treaties between individual contracting states. The section begs the international commission to accelerate the work of the sub-commission which has such a draft treaty under consideration."

3. The third question of the section on prevention was, "What is the best method to preserve the community, especially youth, from the corruptive influence of pictures and in particular from film productions which incite to crime or immorality?"

Considerable discussion attended the consideration of this question and the resolutions almost unanimously adopted in connection with it were as follows:

"a. An effective film censorship should be set up in every country, with the primary object of protecting the youth. It is necessary to take special measures and to inspect cinemas to insure the carrying out of the decisions of the censorship.

"b. The censorship should not be confined to questions of obscenity, but should deal with all matters connected with the cinema calculated to injure or deprave the young.

"c. Special exhibitions with special films should be provided for young persons.

"d. The state should subsidize organizations for the production of films which are of real value for young people and the general public.

"e. The question of the films is of international import and should be dealt with and regulated by international agreement.

"Each country should do all that is possible to prevent the exportation of films condemned by its censorship.

"As regards pictures other than films, the case would be substantially met by the strict enforcement of the provisions of the international convention relating to obscene publications of September, 1923."

4. The fourth question of this section was, "What are the measures to be taken with regard to abnormal adults (persons who are feebleminded—mentally deficient) showing dangerous tendencies? Are these measures applicable to young persons of the same category?"

The resolutions adopted were:

"a. It is desirable that abnormal adults showing dangerous tendencies should be sent by the judicial authorities to non-penal institutions or colonies in which they should be treated and detained until conditionally discharged by the competent authority, who should be assisted by an advisory committee at each institution.

"b. Young persons of the same category should be similarly dealt with, but in separate institutions if prophylactic measures have failed.

"c. Conditional discharge, effective probation, and close supervision of abnormal persons who have been liberated from institutions are an absolutely necessary measure.

"d. From the point of view of public welfare, it is essential to develop institutions for mental hygiene and prophylaxy which would allow us to discover each case of abnormality and mental defect."

5. The final question of the Section on Prevention was: "In what cases and according to what rules is it advisable to have recourse to the boarding-out system for children summoned before a judge or who have incurred punishment for delinquency?"

The resolutions unanimously adopted were:

"a. Children brought before the courts and convicted of offenses should be, where possible, boarded out in selected families in all cases where

their parents were incapable of providing for their moral education. In boarding out, the aim of reforming children for life should always be kept in view.

"b. This method should only be employed where a complete preliminary examination of the child from the physical, mental, and moral point of view has been made and has not shown it to be desirable that he should be placed in a special school or a reformatory school.

"c. It is desirable, in the choice and supervision of foster parents, to make use of the services of either local authorities or of recognized private societies. Moreover, the rights and obligations of the foster parents should be regulated by a written agreement.

"d. The foster family should provide for the child a complete education and a training to earn his living. It is right that the family should be paid for the trouble and expense, but as soon as the child is able to earn his living, he should receive fair wages for his work.

"e. It is necessary that the foster family as well as the intermediary societies should be under public control.

"f. It would be useful to establish special courses of lectures and conferences dealing with the fundamental principles of the education of delinquent children and in choosing foster parents to give preference to those persons who have attended with profit such lectures and conferences."

With the adoption of the above resolutions, the strictly business deliberations of the congress were ended and were followed by a very inspiring closing hour in the form of expressions of appreciation by the various delegates of the British Government's truly splendid and generous hospitality.

The decision to hold the next congress at Prague was received with great acclamation, as was the announcement of Sir Ruggles-Brice's continuance in the presidency of the congress.

While the American delegation was at no time very aggressive in urging its ideas and ideals in prison matters upon the congress, the American point of view usually gained expression whenever a critical point in the deliberations was reached. Repeatedly, for instance, our veteran leader, Dr. Hastings Hart—who was honored by the congress with an appointment to a vice-presidency—helped along with a much needed clearing up of some point of misunderstanding. Among others of the American delegation who should be mentioned are Amos Butler of Indiana—who in the conduct of one of the sections gave evidence of a fine American leadership—Mrs. Hodder and Mr. Bates of Massachusetts, Calvin Derrick of New Jersey, and Mr. Cass, the general secretary of

the American Prison Association, all of whom helped materially in one way or another in the success of the congress.

Finally, the writer takes pleasure in adding a word of appreciation of the unvarying kindness and patience of our American commissioner, Mr. Chisholm, whose task was indeed a very difficult and trying one, and who gave so unstintingly of his time and of his resources to smooth the way of the American delegates.

The writer had the privilege of interpreting to the congress the extremely interesting exhibit of the Commonwealth Fund's Program for the Prevention of Delinquency. The exhibit commanded the serious and respectful attention of many of the delegates, a goodly number of whom expressed the hope that some means might be devised by which the activities of the Commonwealth Program might be better known abroad.

The International Prison Congress just closed marks the termination of fifty years of an international movement in human welfare initiated by that splendid American leader, Dr. Wines. A study of its committments unmistakably reflects a great deal of progress and fills one with a renewed conviction of the possibility of a more intelligent and a more constructive administration of the problem of crime.

COMMUNITY-SERVICE ACTIVITIES OF THE DANVILLE STATE HOSPITAL*

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WHILE mental medicine during the past quarter of a century has kept pace with general medicine and surgery in the scientific treatment of individuals whose mental disease has demanded their commitment to state hospitals, probably one of the greatest advances, especially within the last fifteen years, has been in the field of prevention, in which social-work activities and mental-hygiene movements have played a major rôle.

From time to time accounts have come from various states of results obtained in the way of restoring patients furloughed from state hospitals through follow-up visits and close environmental supervision by social workers, and of adjustments effected in individuals, both adults and children, who were regarded as definite social misfits and community problems. For the most part, however, this work has been done by hospitals and other institutions located near large cities, from which their patients have come, so that supervision was very easily managed. Smaller hospitals, especially those located in rural communities, have limited their community activities to social work of a more or less indifferent type and practically confined to the patient furloughed from the hospital.

Believing that geographical location should be no insurmountable handicap to community work, the authors, in a paper read before the Pennsylvania State Medical Society, stated their position as follows: It is incumbent upon a hos-

* Read before the Forty-third Semi-annual Meeting, Association of Trustees and Medical Superintendents of the Pennsylvania State and Incorporated Hospitals for Mental Disease and Defect, at the Danville State Hospital, Danville, Pennsylvania, May 16, 1924.

pital for mental disease to place within the reach of the communities included in its district adequate facilities for the preservation of mental health, for the recognition and early manifestations of mental disorders, and for scientific study and advice concerning the problems that arise in schools, courts, and homes as a result of conflicts between the normal members of the community and those of its number who, because of mental disease or mental defect, present disorders of conduct that render them distinctly antisocial. The hospital must no longer serve the community apart from it, but rather as a part of it. It must possess a broad enough vision to view itself not as a lonely unit, but as a spoke in the great wheel of mental-health work and preventive mental medicine, contributing in a positive, constructive way to the understanding and treatment of mental diseases and thus becoming a vital, dynamic force in community, state, and national life.

To answer the query whether such a program is merely a beautiful Utopian theory or is adapted to practical application with results that are worth while, we very modestly present here an outline of our community-service department and its *modus operandi.*

In our attempts to reach and be of service to our hospital community, three avenues of approach have been used: first, direct personal contact with the individual patient, including the supervision and direction of patients furloughed from the hospital to the community; second, the medical men in the hospital community; and third, the various civic, philanthropic, social, and educational organizations of the community.

The first step in the carrying out of this comprehensive and somewhat extensive program was the organization of a community-service department, the immediate direction of which was placed in the hands of a director of clinical psychiatry, assisted by one social worker.

Reaching the individual.—The Danville State Hospital is a rural hospital situated in the heart of the mining district of Pennsylvania, with a hospital community of twelve counties, extending over an area of 9,170 square miles and containing a population of approximately 874,000 people. Some of its districts are so remote that it takes two days to bring a

patient from them to the hospital, and for four months in the year many of its districts are practically closed to travel. The first step in attempting to reach individuals in the community, therefore, was the establishment of mental-health clinics at points throughout the district that would be easy of access to the people.

In attempting to secure quarters for these clinics, we were surprised at the indifference with which our overtures were met, and we found that in spite of the educational work in mental hygiene that had been carried on throughout the United States, the citizens of our hospital community, both lay and professional, had practically no conception of the type of work that we contemplated doing among and for them. In the city of Williamsport we were very frankly told that the community was entirely capable of handling its own mental problems and had no need of help from a state hospital for the insane.

In this same city, however, the door opened for us through the coöperation of the secretary of the Social Service Bureau, who arranged to let us use her office twice monthly for the purpose of interviewing a few of our patients who had been furloughed to that community from the hospital. Accordingly, on August 17, 1921, our first mental clinic was opened in a small hall room. Within six months we had outgrown our quarters, and the pressure of work had become so great that we were invited to occupy rooms at the Lycoming County Health Center under the direction of the same individuals who had first refused us admission. Moreover, a full-time psychiatric nurse was employed exclusively for the work of the mental-health clinic. From this small beginning the work has steadily grown. At the request of the communities themselves, clinics were organized at Wilkes-Barre, Shamokin, Sunbury, Berwick, Hazelton, Lock Haven, and Danville, and at the present time we could organize as many more did our personnel and finances permit.

Reaching the physician.—Fully realizing that the busy general practitioner has but little time to give to the consideration of community problems that arise from abnormal mental functioning, and believing that concise information on the etiology and symptomatology of mental diseases and on

methods of early recognition and extramural treatment of such conditions would be appreciated and would result in obtaining their coöperation, we formulated plans to reach the 650 physicians scattered throughout our hospital district. Papers dealing with mental disorder and mental defect were presented in a simple and practical manner before the various county medical societies. The physicians were given to understand that mental-health clinics, together with the services of the hospital staff, were at their disposal for consultation in matters of diagnosis and treatment. Quarterly neuropsychiatric clinics were held at the hospital, for which teachers of neurology and psychiatry were secured as features of the program. Assisted by the physicians of the hospital, these lecturers presented in a practical way the types of patients encountered day after day in private practice.

As a result of these measures, we have secured the most helpful coöperation from the medical men in our district, who have come to look upon the mental-health clinics as consultation centers. To-day the doctor is not asking, "Are the commitment papers correctly made out?" but, "How may I best treat the individual patient at home?"

Public education.—At the beginning of our work, the attitude of the lay public was interesting. Methods of prevention and care as applied to mental conditions were apparently very imperfectly understood, for school nurses, school teachers, visiting nurses, social workers, and parents brought individuals for the purpose of seeking aid in having them segregated from the community. The defective mother with illegitimate children, the immoral girl, the boy with criminal tendencies, and the low-grade idiot, all fell into the same category, and the clinic rooms were crowded with well-meaning, but sadly misinformed members of the community seeking a blanket solution of their problems by commitment of the social misfits as insane or feebleminded. It thus became apparent that if our work was to measure up to our ideals, a very intensive type of public education must be inaugurated, with the preservation of mental health as its keynote. Accordingly, we organized in the various communities mental-health committees to whom we explained the object

of the mental-health clinic and the factors essential to its successful functioning. In addition, Rotary, Kiwanis, Lion's, Round Table, young men's, and civic clubs were addressed on questions relating to mental diseases and their prevention. Quarterly mental-health bulletins were also issued, containing articles, by prominent psychiatrists, heads of the bureaus of the department of welfare, and members of the hospital staff, on the prevention and extramural treatment of mental conditions. These bulletins were circulated throughout the hospital district by physicians, overseers of the poor, and social workers.

Furthermore, believing that teachers in our public schools and students in our universities should be acquainted with the fundamental factors involved in abnormal mental functioning, we made plans to reach the student body in the teaching institutions throughout our district. Courses of lectures on abnormal psychology and mental hygiene were prepared and begun at the State Normal School at Bloomsburg in 1922. A series of six weekly lectures has been delivered at both the winter and summer sessions of the school. This work has gradually extended until at the present time our teaching course includes Bucknell University, Susquehanna University, State College, and the Central State Normal School at Lock Haven. Each of these series of lectures has terminated in a specially arranged clinic at the hospital, which has included case demonstration together with an inspection of the institution and observation of the methods of treatment employed.

Lectures on psychology and nursing in mental disease have been delivered before classes of nurses in training in the Geisinger Memorial Hospital, Ashland State Hospital, and Lock Haven General Hospital, with the result that the attitude of the general hospital toward the mentally ill is being changed, and it is definitely coöperating in the care of mental patients in the community by registered nurses.

With the above historical outline in mind, let us consider in brief detail some of the specific phases of the work to which reference has been made.

MODUS OPERANDI OF A MENTAL CLINIC

The organization and operation of a mental clinic is a comparatively simple matter. Quarters can be secured at general hospitals, Red Cross rooms, or state-clinic buildings, and we have found the state department of health very coöperative in this matter. Six of the eight clinics operated by this hospital have permanent locations at state-clinic buildings, and these centers, conveniently located and of easy access to the public, and housing, as they do, prenatal, nutrition, well-baby, tuberculosis, and genito-urinary clinics, have been found well adapted for good mental-health work.

The next step in organization is to secure an adequate clinic personnel. The ideal clinic should be in charge of a neuropsychiatrist, who should be assisted by a psychologist, a registered nurse, a psychiatric social worker, and a stenographer. The psychiatrist will of course be furnished by the state hospital. The department of welfare will provide a psychologist until such time as some one can be found capable of making the necessary psychometric tests. Local health officers, Red Cross, and visiting nurses' associations can be relied upon for the services of a registered nurse to be present during clinic sessions. If a stenographer is not available, the nurse, with a little help and the aid of a medical dictionary, can soon become efficient in the transcribing of notes and the case records; and if the community is so small that it possesses no social worker, the nurses will generally be found willing and capable of following the patients into their homes to see that the recommendations made at the clinic are carried out.

It now becomes necessary to interest the public, lay and professional, in the project. To this end the local or county medical society should be addressed on the subject of mental disease and mental defect, and assured that the clinic is being instituted not for the purpose of interfering with their business or sidetracking their patients, but rather to be of definite financial and professional help in the matter of caring for the mental cases with which they come into contact in their daily practice. In the work of this hospital, the relations between the institution and the practicing physician have been of the most cordial and helpful character.

In bringing the clinic before the community as a whole, one of our most successful methods has been the calling into conference of representatives from the local medical society, the public schools, the courts, the Y. M. C. A., the Red Cross, the visiting and state nurses' associations, the social-work agencies—in short, all the agencies that deal in greater or less degree with community problems. At this conference, the object and scope of the work are outlined, a mental-health committee is formed, and the aid of volunteer workers is solicited. When these steps have been taken, the work may be considered fairly launched, and from this time on the seed will begin to sprout. Patients will appear in increasing numbers at each session of the clinic, which should be held monthly or preferably semi-monthly, and in communities of sufficient size funds will be forthcoming from community and welfare federation chests. In the city of Williamsport about $2,000 a year is now being provided, and in Wilkes-Barre the clinic has achieved such proportions that Dr. Jesse Paterson Janjigian, formerly at Norristown, is employed as a full-time psychiatrist and social worker, there is a full-time stenographer, the expenses of the psychiatrist are met, and it is planned soon to add a full-time social worker.

In addition to their work for the community, such clinics, properly distributed throughout the hospital district, afford a most valuable means of supervision of patients furloughed from the hospital, for in addition to the fact that these patients may be seen personally by the psychiatrist of the hospital once in two weeks or a month, the social workers and nurses connected with the clinic augment greatly the activities of the social worker of the hospital in the matter of field work.

The scope of clinic work.—A presentation of the work accomplished in the hospital district through the agency of the mental-health clinics, together with an analysis of 700 patients examined during the first two years ending August 17, 1923, has been published in the *Journal of the American Medical Association* for April 6, 1924. Some idea of the continued progression of this work may be gained from the fact that during the seven months beginning September 1, 1923, and ending April 1, 1924, 1,022 clinic visits were recorded, and of

these 436 were new patients. Practically every agency in the community that stands for social and economic efficiency appears on our records as a source from which these problem cases have been referred, and to-day we are of the firm conviction that the mental-health clinic in our hospital district has not only proven its right to exist, but has taken its place in the front rank with out-patient clinics in the fields of general medicine and surgery.

There have been two outstanding criticisms of the establishment of mental-health clinics in connection with a state hospital for mental diseases: first, that the majority of the patients seen will be children and therefore not related to the recognized activities of such a hospital; and second, that the examination of children requires the services of a psychiatrist trained in the examination and treatment of the mentally defective or retarded child.

In reply to the first of these criticisms, we would say that the number of neuropsychiatric adult cases brought to the clinic will depend almost entirely upon the establishment of a cordial and helpful relationship with the physicians of the community. For when the family physician comes to understand that the mental clinic is not an open door to the state hospital and that the recommendation of its psychiatrist is not invariably commitment, he will not refer only the troublesome patient whom he desires to get rid of, but will bring his daily problems, seeking aid in the extramural treatment of his cases of nervous and mental disorders. This is adequately shown by the fact that approximately 50 per cent of our new cases have been adults. It may not be out of place here to mention that in Lock Haven the clinic takes on the aspect of a clinical conference at which from eight to ten physicians are in attendance and the cases are discussed in a very interesting and helpful way.

As to the matter of the examination of school children for the determination of mental deficiency, it is true that this properly belongs to the department of public instruction, but the state hospital, representing as it does the most powerful factor in the community in preventive mental medicine, cannot, until more adequate means have been provided,

neglect that most important part of the social strata, the children of the community.

The social worker.—One of the strong connecting links between the hospital and the community should be the social worker. To this end her duties should be twofold, intramural as well as extramural. In this hospital, her work begins with the individual patient at the time of hospitalization. She secures from the field the data necessary for an intelligent understanding of the factors active in the production of the mental condition. She follows the patient into the wards of the hospital, becomes personally acquainted with him, and at once establishes a point of contact between him and his former environment. She gives him to understand that she is personally interested in his welfare. If his relatives or friends fail to write or visit him, she at once ascertains the reason. She secures information as to the home from which he has come and as to the financial ability of his relatives to help him. When the question of furlough is considered, she personally investigates home conditions. If the patient is without friends or employment, she endeavors to secure these for him, and here her intimate knowledge of the personality of the patient stands her in good stead. When he leaves the hospital, her interest follows him into the community and even after the period of furlough has expired and he has been discharged from the hospital records, she follows him for two years and notes in his case record the progress that he is making. Here again the mental clinic becomes a valuable aid. We have but one paid social worker, but we have twelve nurses and workers connected with out-clinics who are doing definite work along these lines for the hospital.

RESULTS OF COMMUNITY WORK

While two years and eight months is a very short period from which to estimate the results of community work, there are nevertheless certain facts that stand out prominently even in this short time. They may be briefly summarized under the following heads:

1. Results to the hospital.
2. Results to the community.
3. Results to the medical profession.
4. Results in the way of public education.

Results to the hospital.—In considering the value of community-service activities to the hospital, two questions immediately suggest themselves: first, What effect has this work had upon the admission rate? and second, What effect has it had upon the standing population or house census?

In order to answer these questions, a comparative study was made of the hospital records for the two years and eight months since the organization of this work and for the two years and eight months immediately preceding its organization. In this analysis all cases transferred to or from the hospital were eliminated, as the patients removed by transfer are still, so far as is known, being maintained at state expense. Inasmuch as the death rate has remained practically the same, the number discharged by death were likewise excluded. We were, therefore, dealing entirely with patients admitted direct from the community and returned to it by furlough and discharge. This study reveals the fact that there has been a decrease in the admission rate of 6.1 per cent, and while for a number of years the population of the hospital showed an annual increase of approximately 25 patients, the present period has shown, instead of the usual increase, a decrease of 16 patients.

Again, the results of community work have been made manifest in the fact that at the present time we are able to furlough to the community many patients for whom such procedure would not be felt advisable if it were not for the fact that adequate supervision could be maintained through the medium of the mental clinics, the social worker of the hospital, and the nurses and workers in the field. During this period only about 8 per cent of the cases so furloughed—exclusive of those patients periodically furloughed for short visits to their homes and those who have been removed at the insistence of relatives and against the advice of the medical staff of the hospital—have had to be returned during furlough or readmitted afterward.

Results to the community.—It would be impossible to give even an approximate idea of the benefits accruing from the mental-hygiene clinics to the communities included in the hospital district. Fifteen years hence the story may be written, when the children who are being examined and

guided to-day shall have taken their places as adults in the community. We are assured, however, that something worth while has already been accomplished. In the city of Williamsport, opportunity classes have been provided in the public schools, and in the city of Hazelton such classes are now in process of organization. Week after week, patients are coming voluntarily to the clinics seeking help. Judges of the courts are requesting examination for juvenile delinquents and for adult prisoners previous to trial, and are following the recommendations made by the psychiatrist. While among our adult cases examined every type of psychosis tabulated by The National Committee for Mental Hygiene has been encountered, hospitalization has been avoided for 68 per cent of our patients and they have remained in the community. The work has also been recognized by communities and hospitals in other states, and we are constantly receiving requests for information as to our methods of organization and of field work.

Results to the medical profession.—The general practitioner also has felt the benefit of our work in the field. Our relations with these men have been of the most pleasant. We have yet to receive the first adverse criticism of our methods; on the contrary, the physicians of our hospital district have expressed themselves as having come to regard the hospital as a center of instruction and its medical staff as a source of great help to them in their work.

Results to education.—Our work in the educational institutions of the district has been highly appreciated. Beginning with courses of lectures at which attendance was entirely optional, the work won quick recognition for the value of the information imparted. Students filed written requests for its continuation into the summer sessions of the normal schools and universities, and Susquehanna University has included it in the regular curriculum with credits that count toward the college degree. At the close of the present year we shall have reached at least 5,000 students, who will not only listen to the academic instruction, but will pass through the hospital, where they will have impressed upon them the symptoms of mental diseases and the scientific methods employed in their relief and cure. This work has been productive of far-reaching results. The students of two years ago are to-day

teaching and are referring their problem cases for study to the mental clinics; week after week come letters from various parts of the state asking advice concerning some problem child. The presidents and trustees of our universities are very positive in their assertions that this work is of the most constructive type and that its results on their student bodies have already been felt and will continue to bear fruit as the students return to their respective communities.

THE COST OF OPERATION

At first sight it might seem that the carrying out of the above program would entail a large personnel and the expenditure of a comparatively large sum of money. If the work is properly organized and conducted, however, neither of these features need present any serious obstacle. The keynote of success in this, as in all other hospital functions and problems, is efficient organization. To this end there should be established a distinct department of clinical and community work. At the head of this department may be placed the director of clinical psychiatry, who shall be immediately responsible to the superintendent for the activities of the department. He should, with the superintendent, organize and personally conduct a sufficient number of mental clinics to make accessible to every community in the hospital district a recognized center to which patients on furlough may report and to which mental cases from the community may be referred for examination.

The attendance at these clinics of the clinical director himself establishes definite personal contacts, and the community, both lay and professional, soon comes to understand that the hospital has in its midst an accredited representative to whom they may present their problems. Each patient brought for examination becomes of personal interest to the examiner, and the most favorable results can be expected if he keeps in touch with the case and outlines subsequent methods of supervision or treatment until its final disposition. Still further, patients on furlough come to look to the physician as their confidential advisor, and, if they are seen month after month by the same physician, changes in their mental condition can be more promptly and accurately determined than would otherwise be possible.

In addition to his clinic work, the director should be prepared to present, with the superintendent, addresses before medical societies and lay organizations, and to give courses of lectures on abnormal psychology and mental hygiene in normal schools and universities. He should stimulate and aid his workers in the field in the preparation of talks on child psychology for mothers' meetings and on sex hygiene for high schools. He should, with the assistance of the medical staff of the hospital, arrange for clinics at the hospital for physicians and students, and collaborate with the superintendent and the medical staff in the preparation of scientific articles for the medical magazines, as well as of articles for the lay public in the mental-health bulletin, which may be issued at stated intervals.

How much of his time is thus consumed? In this hospital, with its eight clinics and courses of from six to eight lectures each delivered at both winter and summer sessions of five normal schools and universities and three general hospitals, he has left 60 per cent of his time, which has been given to clinical work within the hospital, including charge of the male reception service and one of the male infirmary wards. In addition he has attended staff meetings and supervised the clinical records of the hospital. During his absence, the daily ward rounds have been made by the assistant medical superintendent and other members of the staff. And at this point we should like to express our appreciation of the loyal support of our fellow physicians, whose whole-hearted coöperation has done much to make this work a success.

In this department there should likewise be a social worker whose duties, as previously outlined, should be performed under the direction of the head of the department. Incidentally, a Ford car should be provided, with the part-time services of a chauffeur. We have utilized one of our male nurses for this purpose.

The entire cost for the past year, including every item of expense even to the depreciation of the car, has amounted to but $3,500, and this amount really represents not an item of expense, but—in view of the benefits to the community and the reduction in the hospital census, with its attendant lowering of maintenance—rather a definite saving to the commonwealth.

ABOLITION OF MECHANICAL RESTRAINT AT THE WILLARD STATE HOSPITAL

JOHN B. CHAPIN, M.D.

EDITOR'S NOTE.—The following is a portion of a letter which was written by the late Dr. Chapin to Dr. William L. Russell in 1901. It is of interest, not only historically, but as a revelation of the fine character of the writer, who was a leading spirit in shaping the foundations of the New York State system for dealing with mental disorders. It was he who planned and superintended the construction and organization of the Willard State Hospital, which was opened in 1869. In its general design, which permitted of the classification of the patients in relatively small units, distributed in detached buildings of simple two-story construction, the hospital was much in advance of most other American institutions of the period. Indeed a study of the principles and aims that found expression in the Willard plans would be profitable in the planning of the new institutions of the present day.

REFERRING to so much of your letter as has to do with the abolition of mechanical restraint at Willard, it has often occurred to me as an interesting subject, and how it all came about so far as we were concerned at Willard.

Going back in the history of the care of the insane in New York State, I can say that mechanical restraint, up to the period of, say, 1870, was regarded as a humane measure; indeed, papers have been read and opinions expressed in our association that it was a system of protection for the insane. When I went to the asylum at Utica in 1854, to the best of my recollection there were about six so-called bunks in use. These bunks were boxes closed on three sides, and raised about six inches from the floor. On the top of the box was a cover which was secured to the box or framework of the bed by four hooks, the hooks being in the cover and the staples in the body of the box or bed in the head and foot. The cover was in the form of an arc of a circle, on which slats, with openings so narrow that it was impossible to get the fingers through, were screwed. In order to place the cover upon the bed or box, one person at the head and one person at the foot raised the box, when the hooks were loosened and lowered at one side. Others held to the patient, who squirmed

and struggled to get out as soon as the lid was removed. This enabled the physician to see the patient or examine him. Sometimes it was found very difficult to replace the cover, requiring considerable expertness and agility on the part of the persons in dropping the cover at an opportune time.

Other patients were restrained by means of muffs and wristlets, a strap passing around the back of chairs which were secured to the floors. I cannot recall the number of persons thus restrained, or the number of persons who were permitted to walk about a ward with some form of restraint; probably the whole number restrained was not less than 5 per cent.

Then there was in use also a form of restraint which the attendants called a saddle, and the doctors called "Dr. Wyman's bed strap" after Dr. Wyman, who was physician in charge of the McLean Asylum near Boston for many years. It may not be necessary to describe this saddle. It, however, secured the patient, by means of straps passing over the shoulders and across the breast, to a leather sheet which was about two and one-half feet long by eighteen inches broad. This bed plate or basis was secured to the rail at the head of the bed by means of a strap, and to the foot of the bed by another strap and buckles. The patient was laid upon it and the straps crossed the breast, and the patient was then secured to it. The patient had an opportunity of turning partly from one side to another, but could not sit up in a semi-recumbent position. The feet were secured to the foot strap by anklets, and the hands placed in a muff, so that the patient was confined to a horizontal position, and his motions were generally very much restricted.

There was also in the storeroom at Utica what was called a "composing chair", which was not in use, but was sometimes exhibited as a curious contrivance. It had been an importation and may have had its origin in the time of Dr. Rush; I think it was called the "Dr. Rush composing chair". It was a chair in which a patient sat; it had a high back with a method of securing the patient to the back. On the side each hand went into a box where it could be locked, and made a very secure arm rest. The feet also went into a box and they could be locked and fastened. I do not remember

its being used during any part of the history of the asylum at Utica, but it had evidently been used by somebody.

As I have said above, 5 per cent of the whole population of the hospital was restrained in some manner. At a later date, say in 1866 and '67, there had been an evolution in the methods of restraint, and while the muffs and camisoles were continued, the box bed or bunk had given place to what was considered a great improvement—namely, a crib, the sides of which were of turned rails; the loose cover of the bunk was superseded by a hinged cover, which was raised and lowered by means of hinges on one side and fastened with one or two spring locks. It certainly was an improvement on the bunk, and was very much appreciated.[1] I do not think I overstate the number in actual use in the asylum at Utica during some portions of the sixties when I say that it was not less than sixty or seventy.

The Willard Asylum opened in 1869, and it was then considered a part of the proper outfit of every asylum to have a certain amount of restraint. Willard was equipped with muffs, wristlets, and camisoles, and I think there were two bed straps of the Dr. Wyman pattern that came to be used, though rather infrequently, as occasions did not seem to require it.[2]

During this period and prior to the seventies the use of restraint had been practically abolished in a large number of asylums in England and Scotland. Americans were subjected to considerable criticism for their adherence to its use. It was boldly and openly defended, as articles which appeared in the *Journal of Insanity* during this period will show, as well as discussions that took place in the meetings of the Association of Superintendents. The subject of the excessive use of restraint was a matter of frequent discussion and talk by the physicians at Willard, and, speaking particularly of my own administration, I think I do not understate the use of it at this hospital when I put the number

[1] During the year 1881, the *New York Herald* published a view of the "crib" which the paper said resembled "a chicken hatcher".

[2] When I left Willard there was a barrel, perhaps two barrels, of old leather restraints in the south cellar, which had been there several years, having been removed from use between 1880 and 1882.

of persons in daily restraint at 2 per cent, which was considered a very good result.

During the period between 1870 and 1880, there was a gradual diminution of the use of restraint. How it was to be wholly abolished, did not seem clear. There were then, as there have always been, a number of patients who were very destructive, and the expense of their care was very much increased. The counties objected to paying the damage done to property and to large bills for clothing. I do not think I felt any more acutely than any one of my brethren the unpleasant sights in the use of restraint. It certainly was a painful spectacle to witness. The use of restraint also led to other abuses, such as the unkind care of patients. It induced in the minds of attendants a sense that they were not the companions or custodians or care-takers of patients, but rather their masters. It certainly was a source of cruelty to patients, and led attendants to feel that they had power to impose severe measures, although the hospital rules were strict about the application of restraint unless by the authority of the physician. It was a common report of those who visited foreign asylums that mechanical restraint had been actually abolished, but that it was warranted in American asylums because insanity in the American was attended with extraordinary manifestations such as were not known abroad—that the freedom enjoyed by Americans in their ordinary life led them to excessive acts of violence when any restraint was imposed.

I can well recall my own dissatisfaction with our system, and the proposition was made to our board of trustees to import a certain number of attendants who might be recommended by foreign superintendents and enter them in our service at Willard, with the agreement that they would remain for a year and care for all persons placed in their wards without any form of restraint. I thought we might make a beginning in this way, and the number to be employed need not be large, but sufficient to care for the twenty or thirty persons who were often restrained during any period of the twenty-four hours. There were, however, objections to this as it was alleged that the persons thus imported would constitute a specially favored class, and there might be jealousies

and other difficulties which could not be easily overcome. Nothing was likely to result practically without the coöperation of the medical staff, and this I felt I should have and, as it turned out, did have.

In one ward of the south wing there were four turbulent chronic cases, noisy, destructive, who occupied seats on the old-style of settee to which they were restrained for periods of many weeks—I do not overstate it by saying for months. Whenever the supervisor and head attendant were remonstrated with for restraining these persons, which was painful to observe, they always replied that it was impossible to care for them otherwise because of their resistance and their fighting propensities, and for other reasons. These persons not only showed the excitement and disorder of chronic lunatics, but they were dirty in the extreme, and I always felt that the spectacle of those particular persons was a disgrace, but I did not know how it could be overcome.

The greatest step made in the abolition of restraint at Willard was about the year 1880, and in the care of the persons mentioned above. At Willard we had in the domestic service of the center a young Irish girl named Bridget Halligan, who was transferred to the wards and there found a place on what was then known as the fifth ward. Bridget Halligan had always been a dutiful, faithful person in every position she had held. She was of spare habit, with a thin, sharp, earnest, honest face, and was conscientious, tactful, and resourceful, God-fearing, but not man-fearing. Whether her precious life has been preserved to this day or not, I cannot say. One day in passing through the wards from the second to the fifth, and conscious of our inability to take care of our patients in a satisfactory manner, as I had often felt before, I said to Bridget that if she would take care of the four women whom I had so often seen in the adjoining ward, and others as well, without using any muffs or restraint, I would not only feel thankful to her, but would grant her a substantial increase of wages. I can even now recall the eagerness with which she announced her intention of undertaking the service, and she said, "I will do it, sir."

It has always seemed to me, as I have thought of the abolition of restraint at Willard, which I think was effectually

accomplished during the years 1881 to 1883 and following, that Bridget practically inaugurated the great evolution, for such it actually was. I do not think I am mistaken about my recollection of the fact that in 1883 restraint had been so far abolished in the wards for women and men that the problem seemed to be solved. How it was all brought about, I cannot now state, except that it was accomplished by elevating the quality of the service rendered to our patients rather than by the number of attendants. In all this work the assistant officers were most helpful, and I can name particularly Dr. Carson, Dr. Wise, Dr. Nellis, and Dr. Allison. While they were assistant medical officers, they were assistants and co-workers in the broadest sense. In the same connection I may mention the coöperation of the supervisors, head attendants, and attendants in the wards where refractory patients were cared for, without whose aid we could have accomplished much less than was done. Some of the names have escaped me, but I recall in this connection James Farley, Bridget Halligan, Miss Irwin, and Supervisor John Donovan, of Second Department, North Wing. All afterwards were decided that they had no desire to return to the former system, with its restraints, noise, turbulence, and the like.

As I recall the changes and revolution in the system, there were several indirect favoring, contributory causes. As time went on, we had on the service a body of intelligent attendants who were well disciplined and who gave to the hospital hearty and honest service and were disposed to do exactly what they were directed to do.

Another contributing cause, and an important one, was the making of a round weekly charge, including board and clothing. For a number of years the law was construed to require a separate charge for board and a separate charge for clothing as actually issued, but when we came to make the clothing in the hospital, it was difficult to separate these charges, and we concluded to make one charge, which included the cost of clothing and damage done. After that we had no trouble with counties. Of course, indirectly, there was experience gained and willing service rendered.

A STUDY OF THE WAITING LISTS OF STATE INSTITUTIONS FOR DEFECTIVES IN PENNSYLVANIA

FLORENTINE HACKBUSCH

Field Representative, Bureau of Mental Health, Pennsylvania Department of Welfare

WHEN the Bureau of Mental Health of the Pennsylvania Department of Welfare began the extra-institutional supervision of mental defectives, we realized that one large source of cases would be the lists of applicants for our state institutions. Pennsylvania, like other states, is confronted with the problem of more mental defectives than there are beds in institutions, and there are many applicants for admission to these institutions who cannot be accepted immediately and are put on the waiting list. We wished to know what had become of these people. Were they cared for in some other way? Was everything possible in the way of physical treatment being done for them while they were waiting for admission? Were they becoming more delinquent and dangerous? In the absence of adequate institutional provision, was there anything we could do to make their situation, or that of the family or community, more comfortable?

Since by supervision we mean, not keeping in the community numbers of defectives who ought to be in institutions, but real case-work, the doing of whatever is necessary for the individual defective, we felt that in this group of people we ought to have a field of particular usefulness. Also, since only a limited number could be admitted to the institutions, we thought that with a state-wide view, we should be able to select the most urgent cases for admission and suggest other arrangements for the rest.

Accordingly, early in the summer of 1923, the state institutions furnished us with their waiting lists, with names as far back as 1915, and thereafter each month sent in a list of applicants not immediately accepted and a list of admissions for the previous month. At that time the bureau had two

field representatives who were principally engaged in arranging for mental-health clinics throughout the state and in conducting examinations at these clinics. As they had time, however, they investigated the applicants who happened to live in the neighborhood of the clinics, and this paper gives the results of their work up to June 1, 1924.

Pennsylvania has three state institutions for defectives: Polk State School, with a capacity of 1,710; Pennhurst State School, with a capacity of 1,200; and Laurelton State Village, with a capacity of 150. This last institution takes only feebleminded women. With the original lists furnished in the summer of 1923 and the additional names that came in up to June 1, 1924, Polk had 427 applications on file, dating from 1918; Pennhurst, 1,095, dating from 1915; and Laurelton, 161, dating from 1921. Polk and Pennhurst care for epileptic as well as mentally defective persons, so that some of the applications were for patients of that type.

We decided that we would investigate for Polk and Pennhurst, training schools, no cases over thirty years old. This was a purely arbitrary decision and the limit might just as well have been made twenty-five years. Patients of this age can generally be cared for in some other way than at a training school, and we felt that with the limited time at our disposal, we should confine our efforts to the younger patients. Even epileptics over thirty, in the absence of a separate institution for epileptics, can be cared for much better in a state hospital with other adults. Many of the patients over thirty were probably cases of senile dementia, as their ages ran as high as seventy-seven! To the family or others, unfamiliar with mental disease and defect, these people were "feebleminded" and no distinction was drawn between the different types of institutions. We know in one case that an application was made for an old lady after she had had a stroke at the age of sixty-nine!

The superintendents of all three institutions coöperated with us to the full extent of their ability. Laurelton, because of its limited capacity and particular type of case, could make very few admissions. Polk and Pennhurst admitted almost immediately all cases reported as urgent.

Of the 427 applicants for Polk State School:

32 were over thirty years old
36 were admitted without investigation by us
3 had been admitted just previous to our visit
5 were dead
2 were from the Pennhurst district
4 were duplicates
4 could not be located
3 had moved from the state
1 was unsuitable
3 were not feebleminded
20 were urgent and were admitted
10 were not urgent at the time, but remained under our supervision.

On June 1, 1924, there remained on this list 304 cases in the community uninvestigated.

Of the 1,095 applicants for Pennhurst State School:

114 were over thirty years old
11 were admitted without investigation by us
5 had been admitted just previous to our visit
11 were dead
2 were from the Polk district
36 were duplicates
9 could not be located
5 had moved from the state
4 were unsuitable
1 was reported as no longer necessary
2 were not feebleminded
2 had been admitted to Elwyn
1 had been admitted to Laurelton
8 were in Byberry
11 were in state and county hospitals
9 were in county homes
1 was in a crippled children's home
3 were in institutions for delinquents
21 were urgent and were admitted
20 were not urgent at the time, but remained under our supervision.

On June 1, 1924, there remained on this list 819 cases.

Of the 161 applicants for Laurelton:

1 was admitted without investigation by us
4 could not be located
1 had moved from the state
1 was not feebleminded
1 had been admitted to Pennhurst
1 had been admitted to Polk
1 had been committed to a state hospital
1 had since married and husband and family refused consent to commitment
3 were cared for in other institutions temporarily until admission
2 were at home, very urgent, put under supervision
1 was not urgent, but remained under our supervision
1 was in Muncy, very urgent, and was admitted.

On June 1, 1924, there remained on this list 143 cases.

A summary of the year's work shows:

146 were over thirty years old
48 were admitted without investigation by us
8 had been admitted just previous to our visit
16 were dead
4 were from the wrong district
40 were duplicates
17 could not be located
9 had moved from the state
5 were unsuitable
1 was reported as no longer necessary by the agency in charge
1 was married
6 were not feebleminded
13 were in other institutions for the feebleminded
12 were in state and county hospitals
9 were in county homes
1 was in a crippled children's home
3 were in institutions for delinquents
3 were cared for in Crittenton Homes until admission to Laurelton
42 were urgent and were admitted
2 were urgent, but could not be admitted to Laurelton and are under supervision at home

31 were not urgent at the time and were placed under supervision.

Some explanation and analysis of the various items is perhaps necessary. It was not to be expected, with the limited time at our disposal, that we could in one year visit all the cases and have them listed in the order of their urgency. The institutions, as usual, accepted what cases they could without any report from us. The few cases reported as having been admitted just previous to our visit were due to the fact that reports came in monthly and that a child who was admitted early in the month would not be on our list of admissions until the first of the following month. There were not many of these needless visits, and as they were generally among several in a locality, the time spent on them did not amount to much.

The cases that were dead, that could not be located, that had moved from the state, that were no longer necessary, that were in other institutions for the feebleminded, or that had been committed to state and county hospitals should have been reported to the institution at once by the interested agency. We are making an effort to have social workers understand that case-work with their defectives does not end when an application is made for admission to an institution. It is ended only when the patient dies, moves from the state, is accepted by the proper institution, or is referred to the proper agency for supervision, which in this state is the bureau of mental health. When this idea becomes prevalent, we shall no longer have cases "that cannot be located". If a case is so urgent that it needs institutional care, as evidenced by the filing of an application, it is too urgent to be allowed to drop out of sight.

Our experience with one such case is most illuminating. We had the name of Anna O. of S———, no age, no address, but the name of the certifying physician. The post office at S——— had not the name of O. on its list, but gave two similar ones. One of these homes was visited in the morning before clinic hours, and the other after clinic hours, in order that the investigations might be made while we were in that vicinity. Neither home was the one. The physician who made the certification was then called on during his

evening office hours. He said that he often signed such papers at the request of the officials without seeing the patient, and could tell us nothing whatever about Anna. While on a visit to the institution, the field representative looked over the blank for more clues and found the name of the county clerk affixed to it. On her next visit to S———, she questioned him, but he could recall no details of the case, so Anna seems to be lost forever.

The large number of cases admitted to state and county hospitals shows the ignorance of many workers in regard to the difference between mental illness and mental defect. Many of these cases were considered "feebleminded" until they became violent. Of one it was reported that "he died in D——— Hospital, violently insane".

Of those who moved from the state, we know that one is working in a large manufacturing city in an adjoining state. The mother of another, when she learned from relatives of our inquiry, wrote us, also from an adjoining state, that we could "come and get Mary any time we wanted to"!

The one who was married had an illegitimate child and then married the father of the child. She is just as feebleminded as she ever was, but her family will not consent to any commitment now and they would probably be upheld by the public sentiment of the community. In her case, since she could not be admitted to the state institution immediately, she should have been committed to some home or shelter temporarily. Then the world would have been spared additional members of a rather undesirable family.

The case reported as no longer necessary was not explained by the reporting agency. The child found in the crippled children's home would have been transferred eventually, but was in such wretched physical condition that he did not live long after the visit of investigation.

Of the cases considered unsuitable, one for whom application had been made to a state school was considered more suitable for the state village, since she was an adult and an active sex delinquent. The other four were all young men, high-grade morons, of the defective-delinquent type, who could be more suitably handled as "long-termers" in an institution for delinquents. In each case this was explained to

the officials, and in the case of one of these young men, who later stole an automobile, it resulted in his being sent to a reformatory institution instead of being given the usual short jail sentence "because he wasn't responsible". These cases are kept under supervision. They were all court cases before their mental condition was diagnosed and application made to the state school.

The six who are not feebleminded are all worthy of mention. One is now in a school for the deaf. One who is only lame was to be sent to the state school so that he could learn a trade. One girl, on the basis of an intelligence test made when she was very unhappy and much upset after a delinquent episode, was considered suitable for the state village. A boy, later brought to one of our clinics, was diagnosed as a case of dementia præcox. If the local physician had known the definition of feeblemindedness—"a defect existing from birth or an early age"—he would never have made such a diagnosis in the case of a boy whose history indicated clearly a marked change after fifteen or sixteen. One child was the offspring of a brother and sister, and the agency in charge of him simply assumed that with that parentage he *had* to be feebleminded! (His I.Q. proved to be 113!) Another lad, also seen at our clinic, has a four-plus Wassermann and it was thought that with treatment he would improve considerably. The agency that had him in charge had recently committed to a state school, on the certification of a local physician, a little girl with an I.Q. of 85 and a positive Wassermann, in spite of the fact that our clinic had reported her as not a suitable case. She was of course returned at once. When this agency received the report on the boy, they promptly returned him to his mother. She could not keep the position she had with him to care for, so left the town and now this boy "cannot be located".

The cases listed as "from the wrong district" are due partly to ignorance on the part of the social agencies and partly to the fact that in their desire to have a client admitted to some institution, they make application to all.

The duplicates could be avoided if agencies would coöperate, use the Social Service Exchange, and make careful inquiries as to previous applications. When one agency

does not succeed immediately in securing the admission of a child, the family goes to another one, and so on. One girl, for instance, had three applications filed for her—one by the family physician, one by the district attorney, and one by the directors of the poor. A Polish boy also had three, each under a slightly different spelling.

The nine patients who were in county homes were either of a very low grade of intelligence, requiring only the care of a chronic bed patient, or were of a high grade of intelligence and old enough to help with the work. One girl, for instance, is reported as doing the work of a woman formerly hired for ten dollars a week. These cases are all kept under supervision, so that if there is any change in their condition, they can be committed to some other institution.

When we began this investigation, we expected to find that many of these cases had grown much worse and had become serious delinquents, due to their failure to be admitted to the proper sort of institution. Therefore it was a great surprise to find, of the number studied so far, only the girl previously reported as having married the father of her illegitimate child and three others who had become delinquent. Of course, as noted before, some of the applicants were delinquent at the time of application, but their mental condition had never been considered until the time of the delinquency that brought them into court. One of the three was in jail, one in a protectory, and one in a reformatory. The family of this last boy had moved from the state after his application had been filed and before he was admitted. He could, however, not keep away from the large city that was his former home, and without the supervision of his family immediately got into court.

The three who were cared for in Crittenton Homes until they could be admitted to the state village come from the same section of the state. They were sent to the Home because they were sex delinquents and pregnant. At the Home they were sent to the mental clinic, and when they were diagnosed as feebleminded and in need of permanent custodial care, the Home decided that the only way to do the proper thing for them was to keep them until there was a vacancy, since they could never be rehabilitated enough to get along in

the community. The county from which these girls came is paying for their care in the Home, and this shows an intelligent effort on the part of the interested agencies to make proper provision for the care of their clients. These girls are high-grade morons, of the type that only examination shows to be feebleminded. Provision for this sort of care is temporarily more expensive than allowing the girl to stay in the community until she can go to the state village, but it is infinitely safer and cheaper for the community in the end.

It will be interesting, perhaps, to learn on what basis cases were considered urgent for immediate admission; so a few instances will be cited from the reports.

M. L. is an epileptic idiot girl of nineteen who must be watched constantly. The mother is worn out with her care. The parents have had practically no social life together, since one or the other of them must constantly stay at home. The deciding factor in the case, however, was the presence in the family of two younger very bright children who suffered because of the time and money devoted to the care of M.

C. M. is not allowed in school. He is uncontrollable and vicious. He takes a knife to the members of the family when angry. His mother has remarried and his stepfather will not have him at home. He is inadequately cared for by a grandmother. (The probation officer who made his application was written to three times with no response. The matter of completing his commitment blank was then taken up with another agency, which went to the aid of the rather ignorant family immediately, and the boy was admitted.)

L. K. is an excitable, hyper-active idiot, the third youngest in a large family. He cries all night and keeps the family in a continual disturbance.

N. T.'s mother works out by the day and must leave the girl alone in a rooming house.

A. M. is an unmanageable, hyper-active idiot, who breaks the furniture and the windows. The father has been arrested several times for cruelty in his attempts to control the child.

J. S. runs into her father's barbershop, frightens the customers, and has caused the father to cut several patrons. They try to keep her shut up, but she gets out in spite of them and the business has suffered. Therefore, an older, normal daughter is not receiving the advantages she would otherwise have.

C. W. has been excluded from school on the recommendation of an examiner who thinks special classes are very expensive affairs in which

an imbecile, after many months of labor on the part of the teacher, learns to spell "cat". She has nothing to do at home, and her mother is too busy and too ignorant to train her and keep her busy.

F. V.'s father deserted the family many years ago, and the mother has supported an older daughter, who is now in high school, and the idiot F., for whom she was fortunate enough to find a home with an elderly woman. This woman was unable to care for the child longer and F.'s mother could find no one else who would board her.

P. F.'s mother is sick, with Hodgkin's disease. Another member of the family is a cretin. The baby has tubercular glands and is sick all the time. There are two other children. P. is destructive and hard to care for.

J. S. is a very simple type, in an institution for delinquents and about to be released. He is not of the delinquent-defective type, just easily led, presenting no problem of discipline. He has no suitable home.

D. I. is an idiot of eighteen who will not keep any clothes on. He stalks all over the house like a gorilla, and the house consequently closely resembles a cage in a menagerie. The mother has devoted herself to this boy; she has not been away from home for years. She said that her friends have died and she has not even gone to their funerals. The other children left home one by one because it was so unpleasant, and the only one remaining is a girl of seventeen, still in high school. She is ashamed of her home and has no normal life. Some one had persuaded the mother to make an application for the boy several years ago, but she had done nothing more about it because she had heard that one had to have political influence to get a person into an institution, and besides she was not very eager to send the boy away. It took several months of persuading her to make her realize that at least one of her normal children deserved an opportunity for a normal home life, but finally she consented to have the boy go to the state institution.

G. R. received little supervision at home and was in danger of becoming a sex delinquent. The welfare worker of the plant in which her father worked had filed the application. The mother at first would not consent, but finally became alarmed herself and consented.

It will now be just as interesting to learn why we considered some cases "not urgent at present".

G. D. can be amply cared for at home. He had not learned to read and write after attending school eight years, and his parents thought that after a year at the state school he would come home able to read and write, as a result of some miraculous method used at the school.

W. D. is cared for by his grandmother. At the time when a social agency made application for him, the grandmother was ill and unable to care for him. Conditions changed and she now has a good home for him.

M. V. is an idiot of sixteen who looks about eight. His father works, the only other child of the family is a wage earner, the mother is able-bodied, and there is only *one* boarder. Under the circumstances we felt that the family had some obligations to care for him although the officials of the county thought it terrible that a family should be obliged to have the "disgrace" of such a child.

R. M. is an idiot, the pet of the whole family, who would never consent to her leaving home just now. The application was filed by a public-health nurse who had been duly instructed as to the "menace of the feebleminded" and taught that the proper procedure was to put all of them into institutions. In spite of our attempts to change her opinion, she still thinks that bed-fast R. is going to populate the world with feebleminded descendants.

B. C. lives on a farm, where she is not troublesome to the family or the community. She is under supervision, and as yet it is not necessary for her to have care in a residential institution.

S. A. is an idiot, an only child. In the summer his mother places him on the front porch, where he is kept amused and quiet by passing traffic. In winter she has to keep him in the house and to stay with him, and this she does not like to do. We felt that with the existing scarcity of beds, he was not an urgent case for a state institution, and recommended some private institution to her, if she did not feel that she wished to care for her own child.

E. and M. R. are quiet imbeciles. Their mother is dead, but their father has always been able to secure a caretaker. We felt that this arrangement should continue as long as possible.

The same sort of investigation has been carried on in Massachusetts. The following quotation is from a paper read by Dr. George M. Kline, Commissioner, Department of Mental Diseases, Massachusetts, at the 1924 meeting of the American Association for the Study of the Feebleminded:

"Because of the crowded conditions of our state schools, applications for admissions are made in advance, hence we have long lists of persons awaiting admission. It was decided that the new division [of feebleminded] take these lists and make a survey of the same in order to determine the present status of each case and eliminate all those who are not in need of institutional care at the present time. The advisability of commitment either to an institution for the feebleminded or to the department depends upon the findings in the study. In every possible instance arrangements are made for home and community care, thus very materially reducing the number of commitments to state institutions. The waiting list of applications to the Massachusetts School [at Waverley] was turned over to these workers. The number of names on the original list, submitted May 1923, was 1,467; the number of

cases eliminated up to March 1924 was 731; the number of cases still remaining to be investigated is 736. Some very significant factors are being noted. A comparatively large number of applicants (144 of the 731) have made their own adjustments. Several did not require state care. Some have withdrawn application, particularly those cases in which social agencies made application without the knowledge of parents or relatives. Several cases recorded as emergency cases have not proven to be so; the reverse is noticeably apparent in some cases. Work with the waiting lists of applicants to the Massachusetts School is being continued, and as soon as completed the lists of the other two schools will receive similar consideration.

"The personnel for this work consists at present of three trained psychiatric social workers connected with the Department of Mental Diseases. It is the purpose of this division to arrange the state into districts and to solicit local assistance in the work of supervision. Only those cases which cannot be cared for in the community are to be committed to the institution. In every possible instance the defective delinquent is considered ineligible. Already several social organizations are coöperating and rendering valuable assistance in the survey and case-work."

It will be seen from this report that conditions in Massachusetts are very similar to those in Pennsylvania.

In June, 1924, a third field representative was appointed, and the work of investigating the applications has been carried on much more intensively, in spite of the increase in the number of clinics and other activities in the field. At the end of six months more cases had been investigated than for the whole previous year, and the report for the year 1924–1925 will show a decided decrease in the waiting lists for the state institutions. At the same time more special classes are being established to care for the suitable children in their own communities, and through our clinics more cases are being diagnosed earlier in life and more correctly. Defects are corrected, recommendations are made for care and training, and institutional care is recommended only for those cases in which a study of all the conditions involved has shown the impossibility of care in the home or the community.

ABSTRACTS

THE PROGNOSIS OF PSYCHOSES OCCURRING DURING ADOLESCENCE. By D. K. Henderson, M.D. *The British Medical Journal,* No. 3284: 1090-95, December 8, 1923.

In order to limit the subject, Dr. Henderson has confined his attention mainly to mental reactions of the dementia-praecox type. In his prefatory remarks, he emphasizes the critical nature of the adolescent period, with its possibilities for good or evil development, and the importance of recognizing symptoms of unhealthy mental reactions in the boy or girl at their first appearance, when adaptations and adjustments can be most easily effected. Feeling that one's attitude toward prognosis in any disorder must depend very largely upon one's views with regard to the mechanism of the disorder, Dr. Henderson discusses briefly the main ideas that have been held on the subject of the evolvement of the adolescent psychoses. These he divides roughly into two classes—those that consider these disorders as physiologically determined and those that are based upon the broader psycho-biological conception of adaptation and adjustment. While admitting the value of the work that has been done by exponents of the first point of view, he feels that the attempt to classify mental disorders on the basis of symptomatology and to treat them from the organic, visceral, and toxic side has not proven altogether satisfactory. It has tended to make the problem of diagnosis and prognosis too cut and dried and it has left out of account many factors of vital importance. The psycho-biological conception, on the other hand, which regards mental illness in terms not of clean-cut groups, but of reaction types, involves a consideration of all the factors in the situation and emphasizes the possibility of adjusting and modifying conditions in such a way as to call forth healthier reaction types. He reports a number of cases to illustrate this conception, showing how symptoms must always be interpreted in the light of the personality. Other cases are reported to emphasize the importance of attempting to differentiate between factors that are constitutional and those that are exogenous.

In regard to prognosis, he feels that a grave prognosis is indicated in cases that have shown marked constitutional abnormalities, although this does not by any means preclude the possibility of a satisfactory readjustment under favorable conditions. The prognosis in cases that are largely due to exogenous factors is infinitely better.

While a complete recovery with good insight is comparatively rare in cases of the dementia-praecox-reaction type, a social, as opposed to a medical, recovery takes place more frequently than is generally realized.

THE MENTAL SEQUELÆ OF EPIDEMIC ENCEPHALITIS IN CHILDREN. By Arthur J. Hall, M.D. *The British Medical Journal,* 3342:110–11, January 17, 1925.

Epidemic encephalitis is not predominantly a disease of childhood in the sense that children are more subject to it than adults. But it calls for special consideration in the case of children from the fact that its virus seems to have a predilection for the upper and upper middle nervous centers whose functional development does not begin until some time after birth and whose organization and adjustment are not completed until well on into adult life.

"Clinical pictures thus appear in children which have hitherto been regarded almost as the perquisites of adult or even senile years. Children in whom week after week and month after month sleep cannot be induced at bedtime, even by the most patient mother or the most potent medicine, were almost unknown ten years ago. Paralysis agitans under forty years of age was formerly so rare that Willige, in 1911, could only find records of less than twenty cases in medical literature, and the youngest of these was eighteen years of age. Hooliganism, homicide, and suicide in children of tender years are events to which the community is unaccustomed, and for which it is unprepared. Each and all of these are now recognized sequelæ of epidemic encephalitis in childhood, and indeed are its special characteristics."

In the acute phases of the disease, the mental conditions observed in children differ little from those in adults. In both the effects are much like the effects of alcohol, producing in some individuals marked excitement and hyperactivity and in others drowsiness, lethargy, and stupor. The symptoms are often markedly similar to those of delirium tremens.

The chronic phases of the disease, as manifested in children, may be roughly divided into four groups of cases: (1) the idiot group, (2) the Parkinsonian group, (3) the apache group, and (4) the "difficult-child" group.

The first group is practically limited to children under five years of age. In these cases the upper and upper middle nerve centers, attacked by the virus of the disease while they were still in a primitive and undeveloped state, have been damaged beyond the possibility of repair, so that hopeless idiocy is the result. The treatment of these children presents no new problem.

The cases in the Parkinsonian group are more likely to be above than below ten years of age. The motor disabilities in these cases make it difficult to estimate the amount of mental defect. In many cases there seems to be some loss of mental power; in others the mind is surprisingly clear in spite of the bodily inertia.

The next two groups are closely allied, the difference between them being probably one of degree rather than of kind. Of the apache type, Dr. Hall writes: "The prototype of this group has for long existed in our larger cities, but he is usually rather older. Moreover, he has developed gradually. It is the curious property of the virus of encephalitis that it can suddenly unmask this type in a child who has previously shown no trace of such tendency. In fact, the number of cases of this and the next group who have been described as being hitherto unusually clever at their books, or particularly docile, is quite surprising. In this type the child becomes completely changed in character. He is aggressive, cheeky, and untruthful. He quarrels and fights with his fellows, wanders abroad, is dirty in his habits, shows sexual tendencies, and may even be homicidal or suicidal. Only rarely have these last features been recorded, but one such case occurred in the North of England in a boy of fifteen. He nearly strangled a girl who had laughed at him, and afterwards hanged himself. While this group consists chiefly of boys, girls may be similarly affected, the kind of symptoms differing with the sex. I have seen one typical case in a girl of seventeen, necessitating certification, and another younger girl under my care is almost as bad."

The "difficult-child group" consists of cases that present symptoms similar to those manifested by the apache group, but milder in form. "They, too, are excitable, irritable and quarrelsome. Most of them have nocturnal restlessness and insomnia—but can sleep soundly and will when it is near 'getting-up' time. If they did not, they would obviously become physical wrecks. On the contrary, they are as a rule, in their waking hours, surprisingly alert and active. They are difficult to control, the difficulty varying inversely with the skill and efficiency of those around them and the nature of their environment. Mental efforts soon tire them. That they are mentally inferior to what they were before and to what they ought to be is generally agreed, and this defect is increased by their long illness. Like adult psychasthenics, they cannot concentrate; they have lost the habit of sleeping at night, and their emotions are dulled or even abolished. One little boy of six, a bright, lively little fellow, tells his parents that they cannot make him cry now, and it is quite true. This loss of emotional affectivity in childhood deprives the parent of the chief means of guidance and control. It is as though one were

astride a colt being broken to harness, and the reins suddenly gave way. The whip is now worse than useless, and it requires good horsemanship and suitable country to regain control and escape trouble. That these children can be controlled is shown in many ways. Most of them improve considerably while in hospital with its orderly régime and moral influences. They sleep better and improve generally. Some of them continue this improvement after going home, others relapse in bad environments. They improve also when sent away to the seaside or country, where they are out of doors all day. Conversely, after improving for a time, they are easily made worse by any excitement, even a visit to 'the pictures'."

Doctor Hall feels that there is danger of exaggerating the number of cases in the apache group, since such cases by their very nature tend to attract more attention than milder forms of disorder. "Personally", he states, "I have only seen very few that can properly be classed as such. Others who really belong to Group 4 are made worse than they need to be by the folly of those in control of them. The child's threats and doings are talked of so much in its presence that it is encouraged to do even greater things."

The treatment of cases in these last two groups presents two main problems: "(1) how to protect the community against the apache, and at the same time, if possible, reform him; (2) how to prevent the difficult child from developing into an apache or a wastrel. While institutional treatment may be necessary for the former, in the public interest, yet the collecting together of this type of child and the absence of individual control has many drawbacks for him personally: he needs very much the leaven of normal persons around him.

"In the case of the difficult child, institutional treatment must, if tried at all, be something very different from that which is usually provided under this name. The requisites seem to be: fresh air (seaside or country), small numbers, close individual supervision, plenty of rest interspersed with regulated physical exercise of a congenial kind, carefully graded mental work under an experienced teacher, plenty of good food. It is an expensive and difficult ideal to carry out, but the numbers in any locality would not be large, and it seems as great a thing to save a damaged mind as to save a diseased limb."

MENTAL HYGIENE AND VOCATIONAL GUIDANCE. By Smiley Blanton, M.D. *The Vocational Guidance Magazine,* 3:51–55, November, 1924.

The thesis of this paper is that vocational guidance, to be adequate from the point of view of mental hygiene, must include a consideration of the emotional, as well as the physical make-up of the individual.

To illustrate what he means, Doctor Blanton cites the work of a corps of landscape gardeners: "Some of these are called tree men. Their work requires that they climb and take chances of falling. Another group are called ground men. Their work is the planting and care of shrubbery and the like. These two groups are equal from an intellectual, physical, and vocational standpoint; emotionally they are quite distinct. The tree men like to take chances, love adventure, and welcome the spice of danger. The ground men dislike to take chances; they like the less spectacular, more secure type of work. To interchange these groups would disrupt the organization."

This situation is parallel in all branches of industry, where the failure to take into account emotional factors results in a decreased output and the needless expense of a high labor turnover and frequent strikes. The same failure to consider emotional factors is responsible for many of the misfits in the professions also, with all the unhappiness and inefficiency that they involve. Vocational-guidance work in schools and colleges should be as much concerned with the student's emotional fitness for the work he is planning to enter as with his intellectual and physical qualifications. This is especially true of schools for social workers and nurses and of engineering and business schools. "Indeed it is an anomaly that any school or college should make an intellectual and physical study of the students to see if they are fitted for the work that they are being prepared to do, and neglect an emotional study. A systematic psychiatric study of the failures in industry and in the schools and colleges would yield facts which would be of inestimable value in placing men in industry and in higher education."

As a working basis for vocational guidance, Doctor Blanton suggests that people may be divided according to their predominant emotional trends into the following types: the over-compensating, the under-compensating, the manic-depressive, the anxiety type, and the paranoid type. He discusses each of these types from the point of view of vocational adjustment. An individual of the *over-compensating* type, for example, is driven by a subconscious feeling of inadequacy, insecurity, or inferiority to undertake work for which he is intellectually or physically unfitted. The ambition to become actors or public speakers so often found in people with speech defects is an illustration of this. Occasionally the compensation is successfully carried through, but this is not usually the case. Another instance of over-compensation is the aggressive, bumptious, overtalkative individual to be found in almost every organization. "Often he is a very good conversationalist and may sometimes talk the boss into believing he is efficient and so is given a position of authority

which he cannot fill. Sometimes a great deal of difficulty is encountered before the inefficiency of these individuals is found out."

The *under-compensating* group, on the other hand, is made up of individuals who, because of a conscious feeling of inferiority or timidity, often take jobs far below their capacities. "This was often seen in the army in men who remained privates, corporals, or sergeants, when by education, mental capacity, and opportunity they were fitted to be officers. With the right kind of handling, these men could have been put into positions where their capacities could have been fully taken advantage of. . . . Very often a crisis is necessary to bring out the capacities of these people. In a flood, a fire, or disaster of some kind, these unknown, neglected individuals very often shine forth as efficient executors or administrators and prove themselves far more capable than they had ever dreamed."

Individuals of the *manic-depressive* type are subject to excessive swings of mood, exaggerations of the usual moods every one experiences. They may be either manic or depressive or they may alternate between the two.

"The *manic* type is illustrated by the talkative, excitable, voluble individual who makes a great success as a salesman, speaker, or actor. . . . They usually do not do well in routine or as office workers, stenographers, or secretaries.

"The *depressive* type finds it difficult to succeed in positions where it is necessary to make quick adjustments, especially adjustments to people, or where strangers have to be met constantly. Positions where they are likely to meet criticism depress them and make them very unhappy. No matter how well fitted intellectually and physically the depressive types of persons may be for certain positions, they should not undertake them if they involve continuous adjustment to other people. Their depression is usually interpreted by the public as a 'grouch'; such people irritate the public and their failure to get along accentuates their depression. They usually do very poorly as salesmen and in such positions as ticket selling and library work. Curiously enough, we often find this depressive type in just such positions, and in places where they come in contact with the public."

Again, there is the individual who combines the manic and the depressive types, and who may be very successful during one of his phases and fall down in his work when his mood changes.

The *anxiety* group includes a large number of individuals. Such people worry about their work and fret if they cannot clean up their desks every night. They should not be placed in positions where they cannot clear up the loose ends of their work at the end of each day. They are often excessively orderly. "These anxiety types have a marked feeling of insecurity which makes them constantly on

the alert for failure. In certain positions this has value. They look forward into the future and provide for every contingency. They are excellent people to put in charge of finances; the 'anxious watch-dog of the treasury' is a familiar sight in business, where he scrutinizes every bill. They are admirably fitted for this work, but as salesmen, as boosters, or as advertising men they would be misfits."

People of the *paranoid* type are suspicious, always seeing slights when none were intended, feeling that they are not getting a square deal, and misinterpreting what their associates say and do. "Such people are the cause of a tremendous amount of trouble in large organizations because of this tendency to misinterpret actions and to misstate facts." They are constantly changing jobs because they feel that they are being imposed upon by the boss.

Each of these various types, with the possible exception of the extreme paranoid, is well fitted for some phase of our economic and industrial life. But many of them, if they are to make the best of themselves, need to be helped to an understanding of their temperamental peculiarities.

Studies of emotional make-up should not be concerned only with individuals who are "queer" or who are failing. Every one, regardless of age, sex, or social status, would be the better for it. "None of us functions at his highest level; few of us even approximate it. Often some small, remediable emotional defect distorts the whole social perspective in the way that a mild astigmatism distorts the physical perspective. It is true that these personality tests are not so easy to do as are the ordinary mental and vocational tests. They are more difficult and more prolonged, but the necessity for them is even greater." Mental hygiene, in the broadest sense of the term, has to do not only with those who have reached an advanced stage of mental illness or who have failed in home, school, or industry. It has a larger field in the prevention of nervous and social breakdowns and the successful adjustment of the individual to his work.

THE LIBRARY IN THE MODERN HOSPITAL. By William L. Russell, M.D. *The Library Journal,* Vol. 49, pp. 1063–65, December 15, 1924.

In this address, delivered before the Hospital Library Round Table at the Saratoga Conference of the American Library Association, July, 1924, Dr. Russell outlines briefly the development of the library at Bloomingdale Hospital during the last ten years and formulates the results of his experience as follows:

"1. A hospital population needs a library for the same reasons that other communities need one. Even when a public library is nearby, the sick in the hospitals are unable to go to it.

"2. The influence of reading upon the mind may also, however, be used with benefit in dealing with the mental aspects of illness generally and especially with illnesses in which disorders of the mind are the principal characteristic.

"3. To accomplish this effectively it is necessary to have available a library of specially selected books and periodicals and the service of a specially qualified librarian.

"4. The librarian should be a person who is genuinely interested in people and who finds satisfaction aiding with their problems.

"5. She should by training and experience have obtained a working insight into the problems of the physically and mentally ill.

"6. Probably the best place to obtain the practical instruction and training needed is a hospital for nervous and mental disorders.

"7. The hospital library should receive from the business and medical managers of the hospital well defined consideration and support. It can properly be regarded as a department of special therapeutics and the librarian should rank with the directors of similar departments.

"8. In the selection of books for the library and for individual patients, the librarian should receive the coöperation and advice of the physicians.

"9. The library should be accessible to all persons employed by the hospital, and the librarian should aid them to select books of value to them. She should also instruct the nurses in the use of reading in the care of the sick.

"10. The medical and nursing libraries of the hospital should be under the management of the trained librarian.

"11. Hospital librarians should, by means of their observations, studies, training, and experience, contribute substantially to the further development of libraries and reading in the treatment of the sick."

The Hospital Pre-industrial Shop. By T. B. Kidner. *The State Hospital Quarterly,* 10:445–53, May, 1925.

Mr. Kidner points out that the great problem of the pre-industrial shop in a hospital, especially a mental hospital, lies in the fact that its object is twofold. It aims to prepare the patient to take his place again in the world of commerce and industry, and its work must be organized and directed from the commercial as well as the therapeutic standpoint. This makes it extremely difficult to find adequate instructors for such shops, since few occupational therapists have had the opportunity to develop the commercial point of view, while the instructor with a background of trade- or industrial-

school training has rarely had a chance to acquire the principles that underlie occupational therapy or the technique for applying them.

This problem can be met either by giving the occupational therapist some training in the methods of commercial shops whose aim is production, or by selecting trade workers with the proper social spirit and training them in the aims and methods of occupational therapy. The preparation of such persons for pre-industrial work with mental patients should, of course, include thorough practice training in the occupational-therapy department of a mental hospital.

In regard to the occupations that should be carried on in the pre-industrial shop, Mr. Kidner is of the opinion that only a few varieties need be provided. Quite apart from the practical difficulties in the way of providing training in many lines of work, the object of the shop—the moral rehabilitation of the patient through the disciplinary processes involved in learning a new job—can be attained with a comparatively small number of occupations. Having in mind particularly the pre-industrial shop in the mental hospital, he suggests as the best and most useful form of training for the women patients the wide field of textiles and needle crafts. It is, in the first place, the age-long occupation of women, appealing alike to the home-making instinct and to the creative instinct, and in the second place it is in line with much of the previous work in occupational therapy. Another point in its favor is the comparatively inexpensive nature of the necessary equipment. And lastly, though probably most important of all, there is a practically unlimited field for the disposal of the product in the hospital itself.

For the men patients Mr. Kidner strongly advises woodworking and its allied industries, for practically the same reasons that apply to the use of textiles and the needle crafts for women patients. The shop can not only make new furniture and new fixtures of all kinds, but undertake the repair jobs that are always demanding attention in an institution—mending broken furniture, refinishing woodwork, reseating chairs, and so forth. "One of the most valuable features of woodworking is that it allows so conveniently for grading the work according to the worker's capacity and manipulative ability. Skilled or unskilled, dull or alert, the worker can always find something suited to his ability in a shop where woodwork and the related occupations are carried on."

As to equipment, Mr. Kidner feels that there is a tendency to underrate the capacity of patients and to overrate the possibility of their injuring themselves with tools and machinery, and he advises that the shop conform in all respects to an ordinary commercial

shop. "Up-to-date tools and other equipment should be furnished, and the shop should be laid out in an orderly, formal manner. Work benches should be arranged as to light, as well as for ease of supervision of the workers by the instructors. Most important of all is that all tools should be arranged in racks, plainly in sight. There should be 'a place for everything' and at the end of the day, everything should be in its place. * * * Not only will this prevent the purloining of tools for mischievous purposes, but the orderly habits inculcated by the replacing of the tools in the racks each day will have a salutary effect on the patients, and play no inconsiderable part in their reëducation."

Special buildings to house these shops are already being designed, but experience has shown that all sorts of buildings can be made to serve. The principal considerations are proper light and ventilation and ease of supervision. Except for wood finishing, which should have a separate room, free from dust, a large, open shop without interior partitions is most suitable. Provision should, of course, be made for toilet facilities, an office for the person in charge, and a storeroom for materials.

BOOK REVIEWS

THE DEVELOPMENT OF PSYCHOANALYSIS. By S. Ferenczi and Otto Rank. Translated by Caroline Newton. (Nervous and Mental Disease Monograph Series No. 40.) New York: Nervous and Mental Disease Publishing Company, 1925. 68 p.

As this monograph of a little over sixty pages is definitely addressed to practicing psychoanalysts, a comprehensive review of it in this publication is perhaps not justified. But in the elaboration of this message, the authors have at the same time reviewed in an interesting manner the fundamental trends in the developmental history of the theory and practice of psychoanalysis, and for this reason their contribution may be of interest to a wider audience also.

Their message can be stated very briefly as an expression of a conviction on the part of two highly experienced psychoanalysts, one a medical and the other a non-medical practitioner, that the time has arrived in the evolution of this discipline for a reanimation of the original purpose of psychoanalysis—namely, its therapeutic purpose.

To those not intimately acquainted with psychoanalytic literature this may seem strange, since the popularity that psychoanalysis has gained for itself rests primarily on its alleged therapeutic value in the treatment of various disorders of the personality. But the authors maintain that, owing to the uniqueness of this discipline—*i.e.*, its characteristic of being at one and the same time a method of research and a therapeutic instrument—its strictly practical therapeutic aspect has suffered in the course of its evolution in favor of the more far-reaching and fascinating research by-product which we know as the psychoanalytic theory of human motivation and of human life in general. In this connection the authors call attention to the experience of many practitioners that with the increase in our knowledge of the subject, the therapeutic results with our patients have not been so favorable as formerly, when the main object of the psychoanalyst was the treatment of the patient. It is the object of the authors to show the reasons for this discrepancy and to point the way to a kind of readjustment between the research and the therapeutic aspects of psychoanalytic practice which would permit the free development of each without the stultification of either. And the first step in this direction is the need to bring the practical, therapeutic side of this discipline more in accord with the marked theoretic advances which, it must be again emphasized, were but the by-products of an undertaking that originally had a solely therapeutic purpose.

In their attempt to do so, the authors first of all digress from Freud's original position, more clearly formulated in his paper entitled, *Remembering, Repeating, and Working Through* (1914), in which he maintains that the essence of psychoanalytic procedure lies in facilitating the patient's recall of past events which were inaccessible to him under ordinary conditions, whereas the patient's tendency—indeed preference—to repeat in action those past experiences instead of relating them was looked upon as a sign of resistance and was to be discouraged. They maintain, instead, that a certain amount of reliving is unavoidable, and if it doesn't occur spontaneously, is to be encouraged, first because this is the only way in which certain unconscious material which had never been conscious can be recovered, and, second, because only through a certain degree of reliving can the indispensable affective coloring of the psychoanalytic situation be maintained.

When one remembers that psychoanalysis as a therapeutic procedure received its original impetus from a desire for an improvement upon the hypnotic method of psychotherapy, and when one finds such a veteran psychotherapist as Ferenczi expressing the hope, as he does in this monograph, that hypnosis may in some way be utilized as an adjuvant to psychoanalysis, this stressing of the "affective character" of the psychoanalytic situation, which constitutes perhaps the central aim of the monograph before us, is readily comprehensible. The reviewer does not wish to be misunderstood here as suggesting that the utilization of the affective factor in the psychoanalytic situation is in any way similar to what is the case in hypnosis. The tremendous and undoubted therapeutic advantage of psychoanalysis as compared with hypnosis lies precisely in the radical difference in the way in which a factor common to both—namely, the "affective" relationship between physician and patient—is utilized. The ultimate success of hypnosis depends upon maintaining this relationship as an end in itself, whereas in psychoanalytic practice it is used as a means to the much more important end of freeing the patient from those infantile expressions of affective relationships which are responsible in one case for a neurosis, in another case for a host of the character anomalies that have such tremendous capacity for affecting deleteriously human nature and conduct.

What, then, is meant by the psychoanalytic situation? Rank's definition of it as "an individually determined process of definite duration in the libido development of the patient" suffices for those thoroughly familiar with the practice of psychoanalysis. For the purposes of this review it may be of some value to go into greater detail.

First of all, the reviewer would like to call attention briefly to the two aspects that characterize the event of an individual's submission to a psychoanalysis. On the one hand, it is the expression of the individual's need for help, either because of the suffering incident to a frank psychoneurosis or because of social-environmental complications which can no longer be endured. From a psychoanalytic point of view we know that this recognition of the need for help and desire for it already constitute a favorable indication in the condition of the patient, since they reflect a wish to give up the narcissistic advantages which every neurotic seeks to find in his neurosis. But from the point of view of the analytic situation, we must also see in this event a tendency—altogether unconscious very probably—on the part of the patient, to find a way around his repressing forces and ego ideal that would permit him a reliving of those infantile affective situations of whose causative rôle in his immediate difficulties no patient is entirely unaware. Thus the patient himself brings into the analytic situation the first important condition for its maintenance, the timely and accurate recognition of which is one of the most important technical problems in psychoanalytic procedure. It is the task of the first phase of the psychoanalytic situation to take full advantage of this tendency of the patient to recreate and relive his infantile affective expressions, by encouraging the desire for transference which is common to all human beings and by assisting the patient in overcoming his narcissistic or ego-ideal resistances to such a return to infantile affective relationships.

The question might be asked here: What about the so-called didactic analysis—that is, the analysis that is undertaken presumably solely for the purpose of learning psychoanalytic technique? A complete answer to this question would lead us too far afield from the subject matter at hand. This, however, can be said with considerable certainty: behind every desire for a so-called didactic analysis lies the more or less urgent *need* for an actual analysis. Moreover, any radical departure, during a didactic analysis, from the conditions and technique of an ordinary therapeutic analysis is apt to give the student an entirely erroneous conception of what an analysis consists of.

To return to our subject, the essential feature of the first phase of the psychoanalytic situation consists in the establishment and maintenance of the transference and in the overcoming, through analysis and interpretation, of the resistances that flow from the ego components of the patient—the narcissistic, on the one hand, which clamor for a retention to the greatest possible extent of the advantages gained through the neurosis, and, on the other hand, those that are conditioned by the ego ideal's resisting the tendency

to a reanimation of the outgrown, but inadequately settled problem of the infantile affective fixations. Parenthetically it might be said that these protective resistances which flow from the patient's ego ideal carry a much greater claim to recognition than the individual has any notion of; for, in the first place, the degree of integrity of the ego-ideal constructions which the patient brings into the analysis determines to a large extent the final therapeutic outcome of the analysis—that is, the degree of capacity that the patient is able to mobilize in the service of adaptation to reality under the new post-analytic conditions, stripped, so to speak, of much of the support he had before the analysis from the narcissistic nourishment derived from his infantile and neurotic libidinous expression. In the second place—and this must be most emphatically stressed—such assaults upon the patient's ego-ideal constructions as are deliberately carried out during this phase of the analysis are permissible only as means to the end of bringing about the indispensable, artificially induced regressive neurosis, which this phase of the analysis in fact is.

In connection with this, the reviewer cannot resist the temptation to digress a bit and call attention to two points that seem to him to be of great importance for psychoanalytic technique, notwithstanding the fact that to the experienced analyst these points ought to be perfectly obvious. It is the experience of all of us that one of the most difficult problems in psychoanalysis, and one that still requires much elucidation, is the question of the proper selection of patients for psychoanalytic therapy. I think we will all agree that the diagnostic criteria of the older clinical psychiatry, and even those that made possible the earlier attempts at a classification of the psychoneuroses, are not sufficiently dependable for this purpose of proper selection of psychoanalytic patients. Experience has forced us to turn more and more to criteria that have to do more with the psychological dynamics of the patient. Now it is my impression that a too ready adaptation on the part of the patient to this first phase of the psychoanalytic situation—or, in other words, a striking absence of ego resistances during this initial phase of the analysis—is an indication that speaks rather against the case being a suitable one for analysis.

We see the extreme of this in the schizophrenic, who not only rapidly falls into this artificially conditioned regression, but astonishes us with his facility for the interpretation of symptoms and symbolic speech and gesture. I do not mean by this the ordinary quantitative problem of the transference, which the ebb and flow of the affective relationship during the analysis conditions so markedly. This problem we have to face in every analysis. It is a problem that relates more

particularly to the patient's libido economy. I am referring here more specifically to the patient's ego constellations, which are reflected in the degree and quality of his resistances to this first phase of the psychoanalytic situation.

The second point that has a bearing upon the question at issue and whose technical importance requires constant stressing is the question of the valuation which the analyst gives to the psychoanalytic situation and particularly to this phase, when he is obliged to play any rôle that the patient's infantile libidinous tendencies seek to discover in him. We recognize, of course, that this transitory regressive state is an artificial creation, but it is indispensable in order to make possible the free backward unwinding of the patient's libido. We also recognize that the psychoanalytic situation is a mutual enterprise, so that the libido thus unwound readily finds its cathexes in the analytic situation itself—that is, in the analyst.

Difficulties arise when the analyst forgets the artificial nature of this situation—forgets that his rôle is that of an "as if", of an "imago" figure for the patient—and permits the patient's libidinous manifestation to impress him with the character of reality. In this seems to lie the main, if not the entire, source of those countertransference difficulties which sometimes make the success of an analysis impossible.

Much more deserves to be said on this technical topic, but must be omitted for the present.

How this first phase and the next are actually dealt with according to Rank and Ferenczi can best be seen from a quotation from the monograph before us: "The principal question is how one deals with the phases of resistance and transference, the mastery of which takes place in the main work of the analysis which we might briefly call a libido-privation cure.

"In the phase of resistance in which the ego defends itself, on the one hand, against the unconscious itself, on the other hand, even more against the analysis of the unconscious, the material which appears is principally the pre-conscious memory material of the patient, or the manifest characteristics and ideals which his ego represents. All these 'resistances', varying greatly in importance, which affect the course of the libido transference in the way we have described, are analyzed step by step during the analysis. Mostly the narcissistic resistances, proceeding from the ego, and the ideal formation appear at first; these are particularly difficult to overcome, because the patient, with the full weight of his whole actual personality, opposes the automatic unwinding of the libido attempted by his unconscious. Frequently the overcoming of these ego resistances

succeeds only after wounding the narcissism of the patient, or by means of a temporary repression of his old ego ideal, after which the unwinding of the libido—or, more correctly put, the affective expression of the libidinal instincts and desires—proceeds more freely than before. From the phenomena of the transference, which represents, as it were, a replica of the infantile libido situation of the patient, we succeed in reproducing the disturbed infantile development of the individual by means of transforming the well known expressions of the unconscious into the language of consciousness, and also by means of the tendency to repeat old situations of the libido.

"In the phase of resistance we have to deal with the pre-conscious memory material which the patient, under the influence of the analytic situation, so to speak, collects out of his varied spheres of interest and centers of cathexis. In the phase of transference—in contrast to that of resistance—it is always a question of making conscious the tendency of the libido, operating in the transference, to reproduce situations which mostly were never conscious at all, but resulted from those tendencies and impulses which were partly experienced in the infantile development, but were at once repressed. By analyzing in the transference these, as it were, abortive wishes which continue to struggle for fulfillment in the unconscious, but which the ego has long since discarded (neurotic conflict) we give the patient the opportunity to 'experience' these wishes intensely for the first time, in order, with the help of the conviction which he thus acquires, and avoiding the formation of pathological reactions, to place him in a position of attaining adjustment to reality. The chief resistance which has to be overcome in this process is infantile anxiety, or the uniting [recognizing the relation] of this anxiety with the libidinal parental conflict as an unconscious sense of guilt. The latter in itself already contains sources of conflict, since it results from the struggle of the ego ideal with the libidinal tendencies and the wishes which correspond to them. The neurotic indeed suffers—as the classical example of the obsessional neurosis demonstrates, but as can clearly be recognized in every other form of pathological mentality, such as the perversions or the psychoses, etc.—from an over-measure of this unconscious sense of guilt. If one can succeed in reducing this sense of guilt, which operates out of the repressed material, to a normal amount by in part solving and abreacting it in fear, the libidinal tendencies which this sense of guilt has kept in check and suppressed since childhood venture forth in the form of the transference. They can then be made conscious, and can, as result of the analytic insight, be elaborated by the actual ego in a new

and more useful way. It is well known that this new elaboration can result partly by means of repudiation, the erection of a new ego ideal, partly it can take the form of sublimations, a part can be allowed to express itself."

We have quoted at length from the original in order to show, in the authors' own words, how in their view of the matter the "content" side of the psychoanalytic situation is decidedly subordinated to the "dynamic", experiencing aspect of it. In accordance with this they call attention to the out-of-dateness of a number of technical approaches which at one time or another gave the central characteristic to the psychoanalytic procedure. Thus they pass in review the so-called "descriptive analysis", which limited itself so largely, almost exclusively, to listening to an expansive description of the symptoms or the perverse wishes of the patient, without any essential therapeutic effect resulting from this mere "talking out" because the dynamic factor of experience was neglected.

"A similarly misunderstood kind of analysis consisted in the collecting of associations, as if these were in themselves the essential thing, and not merely rising bubbles of consciousness showing us where, or perhaps at what depth under the surface, the active affects were concealed, and particularly what motives drove the patient in a given case to use the ways of association which he seemed to prefer."

Equally deprecatory is their attitude towards the preoccupation with the detailed interpretation of the patient's symbolic expression, a preoccupation which frequently led to a stressing of the meanings of the "details" to a point that made impossible the understanding of the whole. They deal in greater detail in their criticism of the preoccupation with the discovery and analysis of the so-called "complexes", again showing in a very incisive manner how the individual as a whole was easily lost sight of when this centering upon the discovery of complexes became an end in itself in the hands of some. The same thing applies to a too exclusive concentration upon the curing of the individual symptoms. As the authors justly point out, this can just as easily be achieved by other methods of psychotherapy. The object of psychoanalysis is to render the patient free from the need for symptom formation.

Equally critical are the authors of the tendency to a too free enlightenment or education (intellectual) of the patient and the tendency to a too exclusive concentration upon sexual content. They point out how, as result of such sophistication and over-emphasis of the sexual, the patient may take advantage of this in the service of his resistances. In this connection the chapter, *The Reciprocal Effect of Theory and Practice,* is particularly illuminating. They

stress here the "deeper conviction" which alone is effective as psychoanalytic enlightenment. "This appears to be one of the reasons why psychoanalysm lays claim to a peculiar position, for here 'plausibility' and 'logical necessity' do not suffice as criteria of truth, but rather a direct perception, or rather the experience of the problems in question, is necessary in order to be convincing."

The appropriateness of all these criticisms will be readily recognized once one agrees to the proposition that "the analytic situation gives the meaning and worth to all content, present, past, and future".

The last phase of the analytic situation is described by the authors as follows: "At this point in the analysis, when the libido development of the patient splits, so to speak, and is transferred from the spool of the infantile fixation to that of the analytic fixation, in the course of this unwinding at least all of the pathologic fixations having been reproduced as it were on a film, the intervention of the analyst in the matter of the duration of the analysis takes place. He sets a definite period of time for completing the last part of the treatment in which the libido of the patient, following an automatic course, now shows the tendency to fix itself in the analysis as a substitute for the neurosis.

"In this last phase of the analysis, in which the patient must show that he is able to stand the withdrawal of the libido, new resistances proceeding from the ego naturally appear, which take the form of a depreciation of the whole analytic work and an unwillingness to accept its results, since the unconscious of the patient had become adjusted to accepting the analysis only if it received libidinal satisfaction in the transference. This must now be given up and the results of the analysis and the attendant changes in the attitude must nevertheless be accepted. This constitutes a test of patience for the patient, who from the very nature of the neurotic privation attempts to show that the withdrawal of the libido places the cure in jeopardy, whereas it is in fact the only way in which the analytic task can be successfully completed. The period fixed for terminating the analysis after the transference neurosis has been established must be adhered to exactly, and we should not be misled by the 'progress' which the patient, under the pressure of this inflexibility, may appear to make, into dismissing him earlier, for it is only in this very last phase that all those things which are decisive for the therapeutic result, and to which the early phases were only preparatory, can be accomplished."

The reviewer finds himself entirely in sympathy with the efforts of these two authors to place the main emphasis upon the "dynamics" of the psychoanalytic situation instead of the "content", as we have

gradually become in danger of doing out of a desire to further the research aspect of the psychoanalytic experience. Nevertheless, he is not unmindful of the danger of the pendulum swinging too far in this new direction, so that very important material may not be touched at all, to the detriment of the case. Thus the early hope that, because of this new direction given by Rank and Ferenczi, the duration of an analysis will be materially shortened has not altogether been realized. As regards the last phase of the analysis—the setting of a date for the termination of the analysis and the inflexible adherence to this—there can be no doubt of its extreme therapeutic value if it works.

Whether or not it works, it seems to the reviewer, will depend entirely upon the proper selection of the case and the technical equipment of the analyst. There can be very little doubt of the theoretical correctness of the procedure.

In spite of the length of this review, the reviewer feels that much that is interesting and important in the monograph has not been adequately dealt with here, a circumstance which only strengthens our conviction that a careful study of this monograph is indispensable for every practicing psychoanalyst.

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New York City.

INSTINCT: A STUDY IN SOCIAL PSYCHOLOGY. By L. L. Bernard. New York: H. Holt and Company, 1924. 550 p.

The biological studies in the field of heredity and of instincts begun a generation ago have had considerable influence upon both psychology and the social sciences. For instance, Thorndike's emphasis on the original nature of man has left its mark upon educational psychology, and the followers of Galton in the field of intelligence measurement have greatly stimulated belief in the hereditary bases of human nature. It is Professor McDougall, however, who has had the most profound effect upon the social sciences, with his rather plausible treatment of the instincts and the emotions. Under the ægis, then, of biological thinking the environmental determinism of Ward and others has been brought into considerable question.

Contemporaneously with these developments went the novel departures in psychiatry under the leadership of Freud, Jung, and Adler. These men have shown us again and again the subtle, but real, connection between early environmental pressures and the personality. Although at first glance the psychoanalytic schools seem to be adherents of the thesis of the instinct school, actually they have

shown how varied social and individual developments may be, dependent as they are upon environmental determiners.

Yet about fifteen years ago a movement counter to the emphasis upon instinct *à la McDougall* was already under way from another angle. Watson, following Pawlow, began the investigation of the conditioned responses of animals and children. The whole notion of the rigidity of instincts maintained by McDougall and others began to be called into question. Since 1920, a series of critical papers by Bernard, Faris, Dunlap, Tolman, Kuo, and others have brought sociologists and psychologists face to face with the whole concept of instinct.

The present book is the natural outgrowth of this critical attitude. In it Professor Bernard has exposed a number of facets of the entire problem in a very complete manner. Without denying the existence of instincts, he has made an effort to limit the term rather closely to biological—that is, inherited—structures. An instinct is a "definite stimulus-response" process or "action-pattern" which is inherited. We do not inherit activities—we only "inherit the structure, the functioning of which determines the action-pattern".

Bernard has drawn upon Herrick, in large part, for his own conception of instinct, habit, and inherited structures. He does not seem to know the possibly even more significant contribution of G. M. Child to the entire matter of inheritance and environment. Child's work may, in fact, lead us to a complete restatement of the question of heredity *versus* environment. As the reviewer has elsewhere made comment, the future will probably witness a new version of the whole notion of sharp dichotomy of instinct and acquirement. In this new approach human and social development will be phrased in terms of interacting pressures—internal and external. Only in the constant interplay of these two pressures do we find life at all. Experimental foundations are being given us from physiology for this new interpretation. This is certain, in time, to alter our study of personality and society. If the reviewer were to offer a major criticism of Professor Bernard's book it would be that, in spite of brilliant exceptions in the body of his discussion, he still seems to keep up the assumption of a sharp separation of environment from heredity. Especially is this evident where he lets his own bias toward environmentalism lead him into undue causticity toward the opinions of the opposition.

Turning to the particular chapters of this book, let us briefly summarize their content. The two opening chapters give the general foundations of the problem of instinct *contra* environment. Chapter III—*Organic Basis of Action*—is a review of the biology of instinct

and habit. The influence of the central and autonomic nervous systems on behavior and the possible importance of the endocrines upon action-patterns are well indicated. Bernard's criticism of Kempf's view of the dominance of the autonomic over the central nervous system is in point and should not have been reduced to the apparent inconsequence of a footnote. While the author grants the place of the native reflexes and of the ductless glands in the total behavior of the organism, he holds with Herrick that in man the more flexible controls through the cerebral cortex overshadow the lower-level functions. Thus instinctive patterns come to be submerged under the guidance of acquired patterns or habits. Environmental conditionings bring about great modifications in the individual, subject only "to the limitations of inheritance", which he seemingly considers of little weight.

There follow fourteen chapters presenting the author's critique of the doctrine of instinct. Chapter IV reviews the current definitions of instinct. These run the gamut from the narrow conception of Loeb to the broad, sweeping notions of writers like Veblen and Freud. The confusion of the psychological with the biological conception of instinct is exposed. The whole matter of the so-called "conscious element" in instinct is brought out. Likewise the question of the differentiation of instinct from reflex, on the one hand, and from intelligence, on the other, is rather fully discussed. Chapter V deals with the development of what the author calls "neuro-psychic traits" or habits. He gives three types of habit—those merely automatic, those partially conscious, and those higher forms of habit which involve consciousness. Chapter VI then goes on to treat the whole matter of control of behavior at this third level of habit. Language and symbolic response develop *pari passu* with the development of social culture. Hence, with the advances of modern times, control at this highest level becomes increasingly important.

Chapter VII and Chapter VIII present the current usages of the term instinct and the current classifications of instinct. Chapter IX gives the results of Bernard's analysis "of the works of several hundred contemporary authors" in the matter of their use of the term "instincts". Over three hundred books were examined and extensive disagreement uncovered. As every one knows, the term "instinct" has been employed in the widest variety of senses. The author remarks:

"If one made a sufficiently extensive collection of instincts, it would seem to be possible to show that almost every activity, either learned or determined by heredity, which has impressed some one as important has at some time or other been called an instinct. I have

myself collected more than five thousand of these supposedly instinctive action patterns (sic), representing a vast number of types of action and attitude."

Chapter X goes into the "origins of the usage of instinct", showing how in the field of religion it has taken the place of a metaphysical conception; how in the field of political writing, it has given support to the notion of "natural rights"; and finally how it has come into prominence by essaying to explain the formation and development of society. Chapter XI reviews the problem of heredity and instinct. The author shows the limitations of the more commonly accepted notions of heredity. In the following chapter he reviews the important experimental and clinical material on conditional development. He indicates very well that the development of the organism begins with conception and that the period of gestation has important bearings upon the life history of the individual. The intimate interplay of hereditary beginnings and environmental pressures is brought out, although, as mentioned above, the author does not seem to know the implication of the work of Child for this aspect of his problem. The contributions of Feldman, however, are basic to his discussion throughout.

Chapters XIII, XIV, and XV give a very incisive analysis of certain alleged instincts: the criminal, the maternal, the paternal, the play instinct, the fighting instinct, the instinct for constructiveness, and others. Those sociologists and psychologists who still glibly talk and write of these patterns as instincts would do well to peruse these chapters. Chapter XVI continues this critical treatment, going into the content of a long list of instincts. Bernard reveals the immense overlapping of separate units, and shows again and again the absurdity of calling large patterns of response—such as gregariousness, self-assertiveness, and the like—instincts, in any biological sense of the word. Chapter XVII extends the discussion, carrying it into the field of the so-called destructive instincts and into the matter of special abilities which may be inherited. The extreme claims of many of the eugenists are thoroughly exposed.

There follow, at the conclusion of this extended discussion, two chapters dissecting the McDougall-Shand conceptions of instincts, emotions, and sentiments. There is little left of the neat arrangement of emotion and instinct as laid down by McDougall when Bernard has completed his task.

The final chapter summarizes the author's argument. He indicates the damage done the social sciences and psychology by the loose usage of the concept of instinct to explain and interpret social and human behavior. There is a strong plea for a careful analysis and examina-

tion of the factors in each situation, personal or social, which the investigator should consider unprejudiced by notions of innate tendencies, instincts, emotions, or other vague and rather shadowy terms. Bernard does not deny innate stimulus-response structures, but he does hold these to be secondary to the tremendous changes wrought under environmental conditioning. Just how he distinguishes between a reflex and an instinct in his own definition he does not, even in his summary, make clear. The following quotation from the close of the book will indicate the author's fundamental standpoint:

"The real task before the social and educational psychologists with respect to instincts is to discover the mechanisms by means of which the child and the citizen build up their habits upon the basis of the instincts, directly or indirectly, and by means of which one habit or set of habits is transformed into another. Hitherto they have approached this problem from essentially the wrong angle, that of the analysis of instinct, on the assumption that instinct dominates the development of habit. Both the approach and the assumption are erroneous. The sociologist is demonstrating that the environment increasingly dominates both the content and the direction or functioning of habit formation. It is, therefore, from the standpoint of the content and the organization of the psycho-social environment that the control of the growth of human character should be approached, the instincts being regarded primarily as the original—not necessarily the immediate or the only—starting points in the process. . . . It is not too much to say that the future control of the human race and its civilization lies not through selective breeding of the higher social qualities—although selective breeding of those traits which can be so bred is of the greatest importance—but through their transmission by social contact and control. The overwhelming—and generally the immediate—pressures upon the character-forming process, especially in its more advanced stages, come from the accumulated psycho-social environment.

Kimball Young.

University of Oregon.

Social Psychology. By Knight Dunlap. Baltimore: Williams and Wilkins Company, 1925. 261 p.

Again the question, What is social psychology? Without attempting more definite analysis, it may be said that hitherto there have been two rather easily distinguishable conceptions: first, that of the sociologists who deal with the psychological aspects of sociology; and second, that of the psychologists who deal with the sociological aspects of psychology. The first group is represented by Ross, Ellwood,

Bogardus, and others; the second, by Allport and perhaps Gault. The volume under review makes it necessary, however, to add a third definition: social psychology is sociology written by a psychologist! At least four-fifths of the book can be paralleled by similar chapters in almost any text in sociology. These chapters are those dealing with marriage and the family, religious organization, civic and martial organization, the condition of social progress, and the principles of social organization. The three short chapters not essentially sociological are those entitled *The Field of Social Psychology, Sex Differences,* and *Propaganda.* Yet this confusion of sociology and social psychology may be intentional, for the author in his preface states that his method of presentation will be such that his readers will be prompted to say, "This is not psychology; it is biology" (or some other science). The primary function of prefaces is to afford a means of expression for "defense mechanisms"; perhaps this is not an exception.

Yet, regardless of whether or not the book is properly named (and in this reviewer's opinion it certainly is not), it is nevertheless a most valuable and delightful study. The publishers are not overstating their case when they assert that the volume is "thoroughly readable". The same keen mind that has done so much damage to the prestige of the "instinct school" here devotes itself to a searching analysis of many social facts and problems. The style is stimulating and suggestive. Upon page after page can be found sentences the clarity and vigor of which are in marked contract to the obscurity and technical jargon of far too many scientific volumes.

The author defines social psychology as "the study of whatever the stimuli from other persons have contributed to our conscious lives and to the activity (whether conscious or unconscious) which results from the conscious life". General psychology is interested in three classes of reactions—reactions to one's own organism, reactions to other human organisms, and reactions to other environmental features. Social psychology is differentiated from general psychology primarily by its emphasis upon the second class of reactions—responses to social stimulation.

Of particular interest is the author's implication that social psychology is concerned chiefly, if not entirely, with "conscious" phenomena, and his frank statement that his "treatment is conservative in that it makes no use of 'unconscious mental processes', 'the unconscious mind', or other popular substitutes for scientific principles". Not content with this indirect stroke at the school of Freud, he later calmly remarks, in discussing the importance of the rôle of magic: "The extensive patronage of palmists, clairvoyants, astrologers,

soothsayers, seers, prophetesses, character analysts, and psychoanalysts, and the eager interest in telepathy, spirit photographs, 'ectoplasm', and other spiritualistic fantasies, show clearly that so far as magic is concerned, the Hottentot, the Malay, and the Louisiana Negro have little on the white man."

Sociologists will be surprised to see the culture concept, which seems to be of fundamental significance in descriptive sociology, used in a quite remarkable sense as equivalent to common topics of conversation. "Culture, in short, is a part of language, a means of communication between man and man." (Page 210.) "Under modern conditions community culture is lessened. The younger generation is not oriented in the topics which concern the older generations, and vice versa, hence neither generation understands the other." (Page 211.)

For the clarification of nomenclature and the advancement of science, there should be called without delay a council or convention of all teachers of social psychology and all authors who have written or who intend to write upon this subject. Then, after thorough discussion and argument, social psychology should be given once and for all time an adequate definition—"a show of hands settling the creed of thousands yet unborn". Thereafter let all who violate this decision beware—of the heresy hunters and the reviewers!

H. C. Brearley.

Clemson College.

Sex and Civilization. By Paul Bousfield, M.R.C.S., L.R.C.P. London: Kegan Paul, Trench, Trubner, and Company; New York: E. P. Dutton and Company, 1925. 294 p.

One of the unique features of this book is the author's treatment of his thirteen chapters, which he follows by a summary that gives in a nutshell the conclusions to be drawn from his text. At the end of the general text he gives a bibliography and an appendix on the unconscious idea of male superiority in the writings of Freud.

Viewing the work as a whole, only in their main trends are the author's statements at all applicable, and they cannot be as definitely proven as he states, for his data are colored with the fallacy that woman actually is inferior to man. The work is very well written, and its seeming definiteness may possibly be traced to the fact that publishers are wont to demand specific data, even though the subject be as complex as the question the author asks and endeavors to answer: "Supposing the prejudice and legal disability were completely swept away, would woman in general be able to take a place in the economic field in any way equal to that of man?" One doubts

whether such a supposition can be answered by the author's statement that the present conception of masculine and feminine attributes is falsely based on artificial differentiation and on outworn conventions, and that the chief psychic difference between man and woman in the sexual field is the fact that the man largely concentrates his erotic energy, while the corresponding activity in woman remains in an infantile form that is spread throughout her whole life and occupies an immense amount of her time and energy. Bousfield believes that woman's temperamental difficulties may be modified by a different method of upbringing and an altered set of ideals from childhood, and that only by such a course may woman overcome her complexes and meet man as an equal.

In his effort to make clear the different types of so-called complexes, Bousfield has made the latter appear as distinct entities, quite separate from one another, whereas clinical experience shows that they are oftentimes but fluid states of desire and libidinous energy that do not permit of specific and static designations. The author has selected, in the majority of instances, works of reference which are by excellent authorities, but which if given in complete detail would not lend themselves to the wholesale and positive statements that he makes in his own text. To those who believe that woman is man's equal, not as his competitor, but as the possessor of psychic and physical attributes which make her different from and yet necessary to man, then this book will not be a very convincing argument that woman occupies an inferior position.

L. Pierce Clark.

New York City.

The Self-Directed School. By Harry Lloyd Miller and Richard T. Hargreaves. New York: Charles Scribner's Sons, 1925. 412 p.

This book combines in a unique way practical suggestions for creative teaching and a philosophy of secondary education. While the latter is not presented as logically and succinctly as one could wish, its practical applications are found on every page.

According to the authors, secondary education should promote creative thinking in the six major fields of English, foreign language, social studies, science, mathematics, and constructive arts. They realize that this task calls for an integration of classroom teaching, curriculum organization, and extra-curricular activities. When all of these center upon the one purpose of providing worth-while experiences for the pupil, we shall have a controlled and selected environment in which boys and girls may develop their best potentialities.

This is opposed to lock-step methods of teaching. It provides rather

for differentiated learning within certain common areas. Thus, for example, all pupils may study mathematics and cover certain "common ground", but it is possible to provide as well for differences in interests and abilities through both differentiated assignments or "challenges" and supplementary projects. In chapters 1 and 2 the authors describe the teaching procedure in operation in the University of Wisconsin High School and elsewhere in which this method of teaching is in operation.

As against a curricular organization laid out primarily on the basis of the findings of intelligence tests, our authors plead for a common participation of all children in the six major fields of secondary education. They contend that in practice there is little difference between an extreme elective system and courses laid out to meet what are supposed to be pupils' different life needs. The administration of differentiated curricula calls for so much flexibility and so many exceptions that they differ not at all from free election. Moreover, the authors contend, since in actuality we do not know those who are to take up one occupation as against another, the only intelligent way to predict a child's possibilities is to try him out. This means that each normal child should secure a grounding in all the fields of secondary education, and with the manifestation of special interests and abilities should make progressive specialization within some of those fields. The reviewer regrets that the discussion in the chapters *Curriculum Thinking, Curriculum Building,* and *Curriculum Building and Curriculum Thinking* are not worked out more concretely, as they might have been in a book clearly written for the profession.

This same conception of education as affording opportunities for a creative and original development of youth is discussed in the chapters, *Adequate Schooling for the Youth of the Nation, The Individual and the Broader Curriculum, Semi-curricular and Extra-curricular Activities,* and *Guidance.* The authors believe that while intelligence tests reveal much that is of value for the individual diagnosis and treatment of pupils, they afford no exact inventory of a child's ability and they reveal but a few of the many factors to be considered in educating up to capacity. Running through the book is an attack upon "determinism" in education and a plea for open opportunities for every child.

The book emphasizes the complexity of human nature. The springs of human action are hidden and creative ability reveals itself under the most untoward circumstances. Guidance, therefore, consists principally in furnishing occasions for enlisting the active energies of youth:

". . . there are no appointed paths in modern life. Prede-

terminism and prediction, those insolent futilities of the segregationists, are broken reeds in a fluid world. Continual self-relating and self-adaptation are the conditions of individual self-fulfilment in an ever-changing democratic order of society. The new day demands that the center of gravity must rest in the individual. He must find the purpose of his life by living it. He cannot hope to discover that purpose through any process of inoculation or of indoctrination, nor can a knowledge of what it shall become be transmitted to him either directly or indirectly by any would-be manipulator of human destinies. He must find it for himself through the exercise of free intelligence in the process of appropriating and contributing to his environment, in which he is forming and being formed by it. He is not to be regarded as a tool, a servant, a thing to be fashioned into any kind of subserviency to a superior group, or authority, or external purpose." (Page 383.)

Here, again, the reviewer would have preferred a more specific and detailed exemplification of the authors' views. However, he hopes that all who are interested in the reorganization of secondary education will read the book. It is an expression of faith and optimism in the possibilities of education for all boys and girls, a faith and an optimism held by practical men whose genuine achievements in the realization of their ideals have rightfully earned for them the respect of their colleagues.

V. T. Thayer.

Ohio State University.

Principles of Psychotherapy. By Pierre Janet. Translated by H. M. and E. R. Guthrie. New York: The Macmillan Company, 1924. 322 p.

A book by Janet is always worth careful study, and this is no exception to the rule. On the other hand, there are certain parts in it that do not seem to add greatly to our knowledge or to introduce new conceptions of more value than the old.

The book is apparently intended for popular consumption, and should be criticized from that point of view. The first part of it is taken up with a description of the various types of psychotherapy. This is an interesting and worth-while summary of the various cures that have been practiced. The psychoanalysts will doubtless feel that the treatment of Freud and his theories is a biased one, and will hardly be prepared to accept the author's statement that "psychoanalysis is to-day the last incarnation of those practices at once magical and psychological that characterized magnetism. It maintains some characteristics, the use of the imagination, and the lack of

criticism, the vaulting ambition, the contagious fascination, and the struggle of orthodox sciences."

The second part of the book deals with the principles of psychotherapy. Here one meets with some new formulations which are rather difficult to grasp at times. Constant use is made of Janet's formulations of the higher and lower impulses, the psychic tension, and others which are found throughout the author's writings. In general the mentally sick patient is compared to a concern that is in danger of bankruptcy, and the same laws with regard to income and expenditures are utilized for the patient. Is there some way in which the patient can increase his psychic income? What are the methods of practicing mental economy? On the whole, these chapters form some very stimulating reading. Yet one is left somewhat dissatisfied, and with a certain feeling that a further development of some of the ideas might greatly have increased the book's value.

The third part of the book is devoted to the results of psychotherapy, but it is important to appreciate that the author uses the term in a very broad sense. In fact it becomes so broad that it would seem to include almost everything in the way of treatment.

The reviewer would unhesitatingly recommend the book to all psychiatrists, and would feel that the first part of the book, the discussion of the various types of psychotherapy, could be read with profit by the laity. The last two parts, however, become rather involved, and would not seem to have the same value to the average lay reader.

Karl M. Bowman.

Boston Psychopathic Hospital.

The Personal Equation. By Louis Berman. New York: The Century Company, 1925. 303 p.

We find in *The Personal Equation* another popular exposition of the glands of internal secretion. It has the merits of many books written with similar motives, as well as most of their faults. With its dramatization of the high spots and its neglect of the low, its unwarranted generalizations and attempts to explain altogether too much about character and personality on an endocrine basis, it is an interesting and readable, if not altogether accurate, book.

The book can certainly never be characterized as dry. The author has a very happy facility in the use of figures of speech, especially similes and metaphors, which are a tremendously important part of the equipment of any popular writer on scientific subjects. If he indulges in an occasional hyperbole, it may be looked upon as included in his poetic license.

Valuable as endocrine factors may be in helping to shape that something called personality—and we who are dealing daily with problems of human conduct know that the rôle of the endocrines is important—we feel that the weakness of the book is its failure to take into consideration other factors, psychological and so forth, which also contribute mightily to the shaping of character. It is often said in criticism of the psychoanalytical theories—especially by those who have failed to read even all the original works of Freud, not to mention the contributions of others in the field—that they attempt to explain altogether too much. Strange it is that such criticisms so often come from those who are guilty of the very offense of which they accuse others! At any rate, one knows but part of the truth who fails to appreciate the importance for character formation of certain infantile and pre-infantile factors of a psychological kind. The valuable contributions of Freud's anal-erotic theories, of Abraham, Glover, and others on the part played by oral eroticism, are worthy of much study for the light they shed on this subject. Also much may be explained through the Adlerian concepts which sometimes involve the endocrines only in a psychological way.

The book abounds with statements of facts prettily clothed in colorful hues, but unfortunately it likewise abounds in many other statements not so factual. For example, the foreword states: "The bulk of evidence demonstrates that the changes in constitution and personality, in the embryo, the child, the adolescent, and the adult, produceable by changes in the glands of internal secretion far outnumber the changes elicited by other agencies." This is a very sweeping assertion. One dealing with large numbers of paretics might almost as logically say, "The bulk of evidence demonstrates that the changes in personality in the embryo, the child, the adolescent, and the adult produceable by the lesions of syphilis far outnumber the changes elicited by other agencies."

And since when, we might ask, were "character and behavior, soul and conduct inborn", as stated on page 23? The statement that there are certain inborn dispositions to types of behavior would have been nearer the truth.

When, in telling of the eidetistic faculty on page 62, the author adds, "And the chief insanity of pregnancy is acute hallucination", the reader, if he were a psychiatrist, would wish to take exception to such usage of the word insanity. He would also wonder what the "chief insanity of pregnancy" might be and he would certainly deny that it is "acute hallucination".

Again, when the author writes, "There are the children who present signs of insufficient secretion of the pituitary gland and who

lack inhibiting power and judgment and are always getting themselves and their parents into hot water because of their lack of common sense and moral sensibility and so cannot be trusted'', we might add, ''And there are the children who present the same signs of insufficient secretion of the pituitary as here mentioned who adjust themselves beautifully in all their relations to life.'' We could also tell of cases in which pituitary disorders caused symptoms only in a psychological way—the case with a small-penis complex, the case with an obesity complex, and so on. Pituitary headaches as described by Pardee deserve mention.

And who would care to accept the statement, ''When combined with an over-activity of the thyroid, they [persons with a parathyroid deficiency] are the sensitive plants of human society, at the opposite pole from the vegetative forms of humanity whom we know as cretins and morons''? No one would wish to dispute the hyper-irritability of such a glandular type as this, but the use of the word moron in this connection is not to be sanctioned even in popular writing. Those who have much dealing with morons know that they are subject to the same emotional problems as other classes of individuals and because of the same factors, occasionally endocrine, but for the most part of other natures.

Again, the popular mind certainly might draw wrong conclusions from the statement, ''Evidence has accumulated that the thymus bears a relation to crime as it does to genius and that the thymus must have some peculiar influence upon the blood and nervous system which predisposes to crime.'' The correlation, if any, is most indirect, and we should be obliged to utilize the Adlerian viewpoint to see through it.

On page 45 the author tells us of the dire consequences to the human constitution that accrue from keeping the child too long on breast milk. So long as personality and character are being discussed, the author might well have stressed at this point the unfavorable psychological effect on the child who makes a too protracted sojourn at this ''fount of erotic interest'', as White puts it. Also something might have been said of the disposition of certain glandular types to such sojourn.

Those readers of the work who are lovers of Dickens will find some cause for concern when they find the author giving their old friend David Copperfield the distinction of having been born in a workhouse. Of course, they will know who was born there, and it is to be hoped they will not judge the book as a whole from this incident. But it is just such things as being born in a workhouse, like Oliver Twist, and of being born posthumously in one's own home and even with a caul, as David was, that aid in shaping people's destinies and help to form

their characters, the importance of their endocrine systems notwithstanding.

And thus one could go on with adverse criticisms. It is only fair, however, to state that much could be said that is favorable. This we will leave to the readers themselves, whose good judgment, we hope, will render them cautious and enable them to read between the lines.

STEPHEN P. JEWETT.

Bureau of Children's Guidance,
New York City.

THE INNER DISCIPLINE. By Charles Baudouin and A. Lestchinsky. Translated from the French by Eden and Cedar Paul. New York: Henry Holt and Company, 1924. 229 p.

These authors have attempted to show that Buddhism, Stoicism, the method of moralization of Dubois, psychoanalysis, and so forth, all have as their basis the one principle—training—and that this training or regulation of our tendencies is controlled by our wills. Over two-thirds of the book is given to innumerable quotations and some discussion to show how the will may be trained, whether one be a Buddhist or an analyst. This paves the way for the real issue of the work—a laudation of Coué and his development of auto-suggestion and self-mastery. Only a few pages are devoted to the principle of auto-suggestion and they really hinge upon one fact—a Coué fact that "above all, the will must not interfere in the practice of suggestion. This recommendation is absolutely essential." And there we are left—"Man is master of his fate", and it lies wholly within his power and ability to use auto-suggestion.

FREDERIC J. FARNELL.

Providence, Rhode Island.

WHEN LIFE LOSES ITS ZEST. By Abraham Myerson, M.D. Boston: Little, Brown, and Company, 1925. 218 p.

A major symptom in many nervous disorders—such as hysteria, neurasthenia, and others—is a feeling of fatigue, of world weariness. Dr. Myerson's book is a discussion of this symptom of fatigue or boredom, for which he uses the word "anhedonia". The study that Dr. Myerson has made of this widespread condition is sound and constructive. The book, of course, is written in the popular style and is designed for laymen.

In the opening chapter, the author gives a typical case and goes on to discuss the physical basis of anhedonia. He discusses the way in which our present civilization wears down our energy, speaking of the constant stream of artificial stimuli which pour in, making response to normal stimuli almost impossible. This leads eventually to exhaus-

tion, loss of appetite, sleeplessness, and loss of sex interest and of sex satisfaction.

The author discusses the lack of satisfaction in their life work from which many people suffer, resulting in a feeling of boredom and doubt and a striving for the unattainable. He states that certain people, by their very constitutions, are predisposed to anhedonia. In others, it is brought on by illnesses or by surgical operations. Then, too, there are emotional conflicts that sap our energies, and social conditions that bring with them exhausting competitions and cause anhedonia.

As to the treatment of anhedonia, Dr. Myerson suggests a new philosophy—a new viewpoint and a new insight into the meaning of life and the forces in each individual that drive him forward. He does not neglect physical causes, but insists that good mental hygiene also is essential if one is to recover from the condition of anhedonia.

Dr. Myerson gives us much of his own philosophy of life throughout the book, maintaining that after all there is an optimistic aspect to our present civilization, and that it may be utilized for man's greater benefit.

The book has a pleasant, forceful style. In the flood of books on mental hygiene written by untrained and uninformed notoriety seekers, it comes as a welcome relief.

SMILEY BLANTON.

Minneapolis Child Guidance Clinic.

MENTAL GROWTH OF CHILDREN; IN RELATION TO RATE OF GROWTH IN BODILY DEVELOPMENT. By Buford J. Johnson. New York: E. P. Dutton and Company, 1925. 160 p.

This is a report of the Bureau of Educational Experiments of New York City, covering a period of five years. The major part of the work was conducted at the Nursery School and at the City and Country School. The psychological work of the bureau, begun under the direction of Dr. David Mitchell, has been supplemented by other studies on health, nutrition, play, and experimental education. The present volume is, however, its most comprehensive psychological treatise. The main object of this investigation was the collection of scientific data on mental growth and the relation of rate of mental growth to the rate of growth in other phases of bodily development. This necessitated a coöperative program, which involved records for the same children by the teacher, the social worker, the physician, and the psychologist.

The selection of the tests, the measurements, and the statistical analysis center about the theme propounded by Lucy Sprague

Mitchell in the foreword: "Our first step towards relating our different investigations is to set in order the materials which best lend themselves to the effort at correlation because of their more precise statistical nature . . . they [records of the children] clearly demonstrate that the rate of growth of an individual is of relatively greater importance than the particular stage of development at which our tests locate him." A number of traits of mental and bodily growth are then studied, and the significance of considering the child as an individual is always uppermost. The psychological methods employed are chiefly analytical, statistical, and comparative. The data are fully reported in tables which will be found useful to future research workers. Accompanying them are numerous charts, illustrations of tests, individual profile graphs and records, two film studies of throwing at a target, and a number of brief records. In spite of all this clearly presented material emphasizing the intellectual and motor processes, the reviewer believes that the study would have been improved by the addition of more behavioristic observations. They would have given a more complete account of the child, thereby increasing the practical value and hence the number of readers of the book. In the Nursery School and the City and Country School it ought not to be difficult to obtain such observations together with some introspective data.

The book explicitly deals with exploring and checking up the field of tests and measurements, and as such it will appeal to psychologists in clinics and schools as a valuable contribution. It tests the tests perhaps more than it gives information as to mental and bodily development. It is pretty much a critique of experimental procedure. In view of the fact that the specially selected group of children studied are of mental ability higher than the average, the author warns us against too broad generalizations both as regards the test findings and the rate of growth.

For the study of anatomical and physiological growth, Dr. Johnson has used measurements of weight, height, pulse rate, and blood pressure. She has studied growth in muscular control by means of the Smedley dynamometer, the Dunlap form of tapping plate, the steadiness test, the target test, and the Hopkinson series of coördination tests. Mental development was measured by the Stanford-Binet intelligence scale, the Pintner-Patterson scale of performance tests, the Rossolimo series of dissected pictures, the Witmer cylinder test, the Dearborn reconstruction formboard (1-C), Healy completion test No. II, the diamond-spot series, the location memory test, the opposites, agent-action, action-agent association tests and the ink-blot test. The

above measurements and tests are subjected to a careful and detailed analysis which points out their practical merits and limitations.

Dr. Johnson finds that the Stanford-Binet intelligence quotients of various groups of children of various chronological ages have a tendency to decrease with increasing chronological age, there being a lack of uniformity in mental growth. She attributes this either to a greater mental growth during the first five years than thereafter, or to the inadequacy of the measuring scale. It is probable that both of these factors were operative. She finds also that measurements of mental growth and certain phases of bodily growth repeated from early childhood, about a year apart, show wide variations from the norms obtained from single measurements of large groups. "Certain children vary from such standards by greater amounts than are held to be normal, yet their rate of growth is similar to that of the so-called normal child."

Dr. Johnson states that these standards are unsatisfactory, and recommends that the standards of reference for an individual child should be the standards of mental growth obtained from consecutive measurements of the same child. She might have added that with the perfection of such norms the advice and recommendations of the specialist in child psychology will increase in practical value. Interest and activity in this direction are widespread as regards the emotional, educational, and social development of children. Judging from the studies that have appeared within the last year by Baldwin and Stecher, Gesell, Terman, Watson, and others, there is every indication that progress is being made.

Richard H. Paynter, Jr.

The National Committee for Mental Hygiene,
Demonstration Child Guidance Clinic, No. 1.

The Correction of Speech Defects. By Helen M. Peppard. New York: The Macmillan Company, 1925. 180 p.

This book, by a former director of the Department of Speech Improvement in Pennsylvania, is attractively gotten up, with large print and good paragraph heads. It is divided into two parts. In Part I, *The Teacher and Speech Defects,* the author discusses the psychology and physiology of speech, the relation of the teacher to speech defects, and the methods of making the sounds in English speech. Part II deals with methods of correction; the diagnosis of speech defects is discussed, and methods of treating the various speech defects are described.

The author discusses the speechless child, lalling and tongue-tie, the correction of baby talk, of nasality, and of lisping and stammering.

The content of the book is disappointing. In the discussion of phonetics the author seems to lack knowledge of modern phonetics. She calls *ch* and *ph* double-consonant sounds when they are single-consonant sounds, and she makes the old statement that there are five vowels in the alphabet—namely, *a, e, i, o, u,* and sometimes *w* and *y*. This antiquated statement is the special aversion of the trained phonetician. *A, e, i, o,* and *u* are the names of the symbols in the alphabet which are used to represent the vowel sounds. The names of *a, i,* and *o* are diphthongs. The name of *u* is a consonant, not a vowel. The names of *w* and *y* are consonants, and only the name of *e* is a vowel. There are several other misstatements which show a lack of knowledge of modern phonetics.

In discussing the speechless child, the author does not mention the fact that speech is often not developed because there is no necessity for speech response in the child's situation, and she makes no mention of the fact that lisping is due to infantilism, the patient holding on to this type of baby talk to keep his beloved infancy. The whole chapter of giving speech to the speechless child is faulty. It is assumed that treatment should be the same for all ages, and the methods that are advocated for giving speech to the non-speaking child are too technical for use with small children. Moreover, the laws of speech learning are violated. Children do not learn words syllable by syllable; they learn by whole words.

The following suggestions are given for teaching the speechless child "mother". "In teaching a word like mother, begin by teaching him *m,* then *o,* then *mo.* When he says *mo* correctly several times, teach *th-er.* Put *th-er* together, *ther.* Then have him practice the first group *mo* and then the second group *ther.* All words should be brought about in this manner in children with this attack of speechlessness." Such a method is much too complicated for any young child to follow. A child would have to be eight, nine, or ten years of age before he could use this method, and then it should be used only with children who are deaf. Speechlessness due to other causes should be treated otherwise.

The author's method of treating stammering and stuttering is a combination of vocal drill, phonetic exercise, and crude suggestion. She speaks about emotional tendency and psychoneurosis in a very loose way. "One of the chief difficulties in dealing with a stammerer", she states, "is his emotional tendency. He is, in a majority of cases, controlled by his emotions rather than by his reason. He can often be reached by likening his weakness to a 'yellow streak'. In this way his combative spirit is aroused and a constructive mental attitude is developed." An example of the loose use of words is

this sentence: "Fright, shock, psychoneurosis, or similar causes develop a certain mental upset that has been likened to a 'yellow streak'."

In correcting the stammerer, vowel exercises and complicated sentences are used, such as: "Mother made a muff." "Mix the milk with mush." Such ancient drills as pah, poh, pee, poh, pah are used. Exercises of this kind usually bore the stutterer to tears, or if he does try to take them, it makes him more speech conscious than ever and exaggerates his difficulty. Those interested in speech defects will find the book of little benefit.

Smiley Blanton.

Minneapolis Child Guidance Clinic.

The Psychology of Emotion, Morbid and Normal. By John T. MacCurdy, M.D. New York and London: Harcourt, Brace and Company, 1925. 589 p.

This volume is the result of the author's long experience in the study of affective disorders, fortified by stimulating personal contacts with the medical officers and case records of the Psychiatric Institute at Ward's Island, New York. The book covers such a breadth of territory and enters into discussion of so many topics that it does not lend itself easily to review, but must be read through for an understanding of the author's attitude in its entirety.

One excellent feature which is too often lacking in philosophical and psychological literature is the care taken by the author to define terms as he understands them and in the sense of their use in his book. For example: "Affect is any subjective experience that, when examined introspectively, is considered to originate in or belong to the subject's individual organism. It may be felt to be either mental or physical, to be stimulated by a sense perception, by a thought, or to be causeless. But in no case is it thought to be a quality of the stimulus except in relation to the subject." And again: "Personality may be defined as an integration of the sum total of the reactions of an individual that are peculiar to that individual." There is also an appended glossary of terms for the use of the lay reader.

Considerable space has been accorded to the description and critical discussion of the theories of Dewey, McDougall, Morton Prince, and others, while the views of Freud and Janet have received little comment. Obviously there is something wrong here, since these two investigators, above all others, have contributed most toward an understanding of the relations of the emotions to psychogenesis.

A large number of case notes, illustrating the various clinical

features of the affect disorders—such as the stupor reactions, the involutional melancholias, manic states, anxiety states, depressions, and perplexity states—are offered as evidence of the desirability of modifying Kraepelin's classification of the "mixed states", and an arrangement is made to include the new clinical groupings of benign stupor and perplexity states. The case notes emphasizing these new groupings as affect disorders are not always convincing and many of the symptoms mentioned are schizophrenic to the extent that no violence would be done were they classed in the dementia-praecox group.

In discussing these symptoms, MacCurdy has given us a better understanding of the dynamic mechanisms that produce them than can be obtained from Kraepelin's descriptive accounts—but perhaps these descriptions would apply as aptly to Kraepelin's original names for the subdivisions of the affect group. In fact, many of the criticisms appear to be rather academic than fundamental in import.

Of course, there are many theoretic and practical points scattered through the book with which the adherents of "behaviorism" will take issue, and although the author is admittedly not at all in sympathy with behavioristic theories, it seems that behavioristic ideas and scientific attempts should receive due consideration and not be dismissed as "silly". They should either be ignored or dealt with fairly.

As a whole, the book is notably thought stimulating. Excellent critical reviews of the older theories of emotion are given, interesting clinical subjects are presented, and studies of the normal states, including those of dreams and emotions, serve to render it well worth reading.

Nolan D. C. Lewis.

St. Elizabeths Hospital.

Les États Dépressifs et La Neurasthénie. By Maurice de Fleury. Paris: Félix Alcan, 1924. 171 p.

It is undoubtedly most satisfactory to have a firm belief about any medical subject and to feel called upon to support it. Under such circumstances one must get all the pleasant sensations that the propagandist is supposed to have. The author of this book, Dr. de Fleury, has such a point of view concerning neurasthenia, and therefore is able to write his little book with much force. It is a definite portrayal of his own ideas about neurasthenia, and he expresses them without any undue hesitancy and with but little consideration of any contrary opinions.

The author begins his book with a full preface in which he gives

a classification of mental diseases. This presents very well the modern French point of view, which differs considerably from the current viewpoint of the majority of American psychiatrists.

The first striking point is his classification of what he calls the accidental or toxic infectious psychoses. These are alcoholism and the various toxicomanias; mental confusion; *true neurasthenia;* dementia praecox, hebephrenocatatonic and paranoid; chronic hallucinatory psychoses; general paralysis; idocy; epilepsy; organic dementias; and senile dementias. This classification calls attention to the fact that so many of the French consider dementia praecox as a definite organic psychosis, the pathology of which they believe has been satisfactorily described by Klippel and Lhermitte. It is also to be noted that true neurasthenia falls in the group of organic psychoses. This is the theory that the author holds and it is his first premise concerning the condition.

With this point of view in mind, he distinguishes the true neurasthenia of Beard from the psychoses and the minor psychoses such as mild depressions, which he considers are periodic constitutional disorders. He is in dispute with Dubois, whom he considers as a very serious menace to the proper understanding of neurasthenia. He defines true neurasthenia as follows: "It is accidental and not constitutional; of a toxic infectious nature. It is dominantly characterized by a state of fatigue which is not an imaginary or hypochondriacal fatigue, but a true physical depression, objectively established by hypotonia of the muscles and of the vegetative system, and by a lessened functioning of the glandular system. It is primarily somatic and only secondarily psychopathic. It is curable. Appropriate treatment has a manifest action upon it. This treatment, purely physical in the first phase of the disease, should be physical and psychic when the mental state has become established."

According to this differentiation, a true neurasthenia is a very rare condition. For instance, during the war in the psychiatric service a survey of from 6,000 to 8,000 neuropsychiatric patients produced only a scant 100 cases of what the author considered true neurasthenia.

The symptoms of neurasthenia, as described by the author, are (1) fatigue, (2) circulatory difficulties, (3) troubles with the gastro-intestinal system, (4) effects as seen in the examination of the urine and nutrition, (5) genital asthenia, (6) troubles of sleep, (7) painful phenomena, and (8) the neurasthenic mental state. He states that fatigue can be demonstrated objectively by the dynamometer and ergograph, as well as evidence of asthenia of the voluntary musculature. The blood pressure is abnormally low in the majority of cases.

However, where arteriosclerosis is common, hypertension may exist. He also states that there is a reduction of the oxyhemoglobin. As improvement takes place, the blood pressure and the effect of the oxyhemoglobin increase. The gastro-intestinal troubles, he thinks, can be also demonstrated. These he emphasizes as symptoms and not as causes. The examination of the urine shows, in many cases, abnormalities as to quantity, specific gravity, acidity, uric acid, urea and phosphates.

The mental state of the neurasthenic, he feels, is definitely secondary to the physical condition. The patient is weak and tired. He is incapable actually of doing any sustained mental or physical work. He will make an effort, he will go so far, and then the fatigue stops him, and this, the author thinks, is never due to the mental state of the patient, but is caused by the actual physical distress. He insists that there is only one cause of neurasthenia and that is fatigue. He states that there is no such thing as traumatic neurasthenia, which is a neurosis and not a true neurasthenia.

With this point of view, it of course follows that the treatment of neurasthenia depends upon building up the physical condition of the patient, and for this purpose Dr. de Fleury has what we may believe to be a naïve confidence in the effects of drugs like strychnine and arsenic.

Dr. de Fleury has presented his point of view clearly and concisely. The book contains many interesting descriptions of the various types of mental symptoms seen in the mild depressions, hypochondriacal states, emotional disturbances, and the like. There is a rather satisfactory account of the various types of insomnia, and a few suggestions for treating insomnia. The facts that the author marshals to prove the organic nature of neurasthenia, however, are not so readily acceptable, and the reviewer is left rather cold and unable to accept their importance with the same degree of assurance as does the author.

The book is really quite short and condensed, much more so than one would think from the fact that it has 171 pages, as each page contains only about 160 words and there are many breaks. It is, therefore, short enough to be hurriedly glanced through with profit.

Harry C. Solomon.

Boston Psychopathic Hospital.

Common Symptoms of an Unsound Mind. By G. Rutherford Jeffrey, M.D. New York: Paul B. Hoeber, 1923. 264 p.

This little volume, by the medical superintendent of the Bootham Park Hospital, York, England, is designed as a practical guide for

the general practitioner in the evaluation and nosologic interpretation of the more gross and elementary symptomatology manifested by persons suffering from mental disorders. The presentation is outstandingly pragmatic, descriptive, and as it were "botanical", not to say distinctly empirical. It is obviously intended for the novice and the only casually interested or concerned. No attempt of any account is made to bring out the very real importance and significance of recognized fundamental biologic and social factors in relation to psychopathologic processes, nor is there in any sense an adequate or modern treatment of the dynamics of conduct patterning, the rôle of personality relations, or the questions of constitution and disposition. In fact there seems to be a signal disregard of much of the exceedingly important and essential contribution of contemporary psychiatric thought and investigation. No attention either is given to semeiology or therapy. The nosology is, to say the least, old-fashioned and incomplete, only the psychoses being considered; nor is any mention made of any other than the purely social or conduct manifestations of those suffering from mental disorders, pathological response at the psychic level being the only factor considered and even that with almost exclusively objective emphasis.

This book has seven chapters. In the first, the introduction, the author comments upon the obvious difficulties, diagnostic and social, that confront the examining physician in relation to psychiatric cases. The second chapter is devoted to the consideration of delusions in the recognition and identification of mental disease. Jeffrey speaks of three major types of delusions—to wit, the suspicional, the grandiose, and the depressed, and proceeds to their consideration more or less in detail—although admittedly at times rather loosely and obscurely—in relation to two types of syndromes: first those characterized by "mental enfeeblement" and second those marked by the absence of that quality. Under the former are listed general paralysis, senile and organic dementia, "primary" and "secondary" dementia (sic), congenital mental defect, epilepsy, and chronic alcoholism. In his second category, the author includes "simple mania", "simple melancholia", states of acute confusion, and paranoia. In his third chapter, he takes up the problem of perceptual disorder and presents an elementary and rather descriptive consideration of illusional and hallucinatory disturbances, adhering to the formal sensorial classification. The four succeeding chapters are devoted to a discussion, largerly empirical, of the significance, from the standpoint of underlying mental disorder, of exaltation, excitement, depression, mental confusion, and altered conduct.

The last chapter Jeffrey devotes to the discussion of forensic rela-

tions. In it he comments upon the necessity of a dual objective in the handling of mental cases—to wit, the conservation and furtherance of the interests of both society and the individual. He also expresses himself as opposed in an unqualified sense to the concept of partial responsibility or "sanity except on one point". The apparent gulf between medicine and the law in the disposition of criminal cases that present a psychopathologic fact is disparaged, but no apparent attempt is made to formulate any rationally constructive plan in solution.

In closing Jeffrey sounds a note of warning as to the community menace of the psychotic, which indeed impresses the reviewer as a dominant emphasis throughout the book, rather overshadowing that of the realization and appreciation of the plight of the afflicted individual himself, socially and personally, the real nature of his difficulties, and those measures specifically indicated in truly rational and constructive alleviation.

In a word, this work is not to be regarded as a textbook on psychiatry or as in any sense an actual contribution to psychiatric thought, but merely what its title indicates it to be—an elementary handbook for the examining practitioner, to assist him in his work of institutional certification. Within the limits of this purpose, the book is undeniably useful, particularly since, although from the point of view of psychiatric terminology somewhat archaic, the style is easy, informal, on the whole lucid, and literary, marked throughout by an attractive naïveté, modesty, and sincerity.

THEOPHILE RAPHAEL.

State Psychopathic Hospital, Ann Arbor, Michigan.

MIND AS BEHAVIOR AND STUDIES IN EMPIRICAL IDEALISM. By Edgar Arthur Singer. Columbus: R. G. Adams and Company, 1924. 301 p.

In the year 1911 Professor Singer published an essay entitled *Mind as an Observable Object.* In that paper he argued that mind *is* behavior. This identification of mind with body was taken by many of his critics as merely a variant of the old doctrine of materialism. Professor Singer attempted to clarify his position in succeeding papers on consciousness and behavior, thereby freeing his conceptions from what some hold to be the taint of mechanism. These various articles are now brought together and unified in Part I of the present book.

In the chapter *The Pulse of Life,* the author develops the interesting thesis that *life* resembles a wave moving through a medium and preserving its self-identity; the pulse consists of a non-additive

assemblage of elements which, as a *group,* may be defined in terms of purpose, choice, and freedom, though the elements in isolation behave mechanically. The author is thus in line with the present fashion in thinking, which Lloyd Morgan has popularized by the term *emergent evolution.*

Professor Singer modestly concedes that he has no reason to believe that his own writings have inspired any of those psychologists who now advocate *behaviorism.* Even if it were otherwise, he would be in no hurry to claim this doubtful honor. Professor Singer's conception of life and mind is distinctly teleological. There are, of course, a number of types of behaviorism. The "methodological" behaviorist need not deny consciousness, but he must hold that it is inaccessible to scientific observation. Thus Dr. H. M. Johnson, who affirms the "privacy of consciousness", rejects the introspective method because the problem is to find the relation between two variables when only one, at the most, can be given. This means that the Weber-Fechner law is dead. But the ghost of the corpse will not rest easy. It is curious to observe how, in spite of its known limitations, this law will not remain buried. Professor W. Köhler (an exponent of *Gestalt* psychology) finds in Weber's law of sensation difference a similarity to the formula underlying the difference in ionic concentration of solutions. The contours of the visual patterns, which correspond to the retinal patterns, are constituted by the differences of electrical potential which mark out the physiological surface boundaries of the cortex. Professor W. P. Montague attempts to derive the law of psycho-physics from his theory that the synapse acts as a trap which levies a minute toll upon the kinetic energy of the nervous impulse, and thus builds up a continuum of potential energy, which *is* consciousness. In his chapter on sensation-intensity, Professor Singer also gives a mathematical deduction of the psycho-physical law, which, he believes, is more flexible than the traditional statement. Unfortunately he does not discuss the relation of his own doctrine to other theories of the relation of consciousness to the nervous system. However, he would probably deny the assertion of the methodological behaviorist that there are two variables.

In Part II, *Empirical Idealism,* he elaborates on the argument that the more spiritual objects of human interest, being expectations of probable behavior based upon the observation of actual behavior, can be approached by plain experimental methods.

The entire book is written in a genial style and the book may be recommended as a stimulating and provocative (though to the present reviewer unconvincing) discussion of this highly interesting, but most baffling of the problems of theoretical psychology.

Ohio State University. OLIVER L. REISER.

PSYCHOLOGY FOR CHILD TRAINING. By Arland D. Weeks. New York: D. Appleton and Company, 1925. 312 p.

We have here a book written for the benefit of those parents who, with little formal background in psychology, mental hygiene, or pedagogy, still realize that there is a scientific approach to their problems. It is a book very obviously written for the layman, and because of its style and the way in which the material is presented, it holds the attention and interest of the advanced student with some difficulty. In true textbook fashion—and usefully for the inquiring parent—each chapter ends with a list of exercises and questions and a short bibliography.

Of the twenty-five chapters that make up the book, ten are devoted to a discussion of instincts as innate determining factors which appear both in the child and in the race. This is elaborated by the statement and support of the recapitulation theory, an explanation of the survival of instincts on the basis of their utility, and specific suggestions, since instincts may be misused in our present-day society, as to how these primitive tendencies may be directed into proper channels. Though the classification of instincts that Professor Weeks uses as the basis of his discusion of behavior tendencies may be refuted by any number of psychologists, perhaps that is a less important point to make to parents than the facts that behavior is modifiable through the use of substitute stimuli and responses, and that motivation is the keynote to all such learning.

To the parent for whom this information is new, the working principle that a child is an individual in the process of growth toward maturity, and not an uncontrolled, untutored replica of that maturity, will be helpful and stimulating.

One deplores the two "typical" portraits, one of adolescent youth, the other of the juvenile delinquent. It seems an unfortunate way in which to present objectively measured traits and factors. People are only too apt to generalize from ordinary statistical tables even when in them they are compelled to recognize ranges and variability. These two portraits may be rendered harmless by the inclusion of the chapter on individual differences, but one wishes that so unsound a method of presentation had not been used.

It is wise for Professor Weeks to point out that the school, with its rapidly developing interest in child psychology, does not invite the home to drop out of the picture, but, instead, challenges it to be a more effective, conscious factor in the child's life. The chapter on training to think is valuable in its suggestion that normal children are capable of forming independent judgments which many parents, hindered by their own feelings of insecurity in a world of competition, are prone to stifle. Reflecting the same school, in the chapter on

individual differences, the author is voicing the accepted principle of mental hygienists that "success is as much a matter of organization of effort as one of mental ability. Hence the intelligence quotient has by no means the last word." A further elaboration of this statement from the standpoint of mental hygiene would have been an excellent addition to the chapter. General suggestions such as these constitute the most admirable contributions of Professor Weeks' book.

JEANETTE REGENSBURG.

Bureau of Children's Guidance,
New York City

OCCUPATIONAL THERAPY FOR THE MENTALLY AND NERVOUSLY ILL. By Louis J. Haas. Milwaukee: The Bruce Publishing Company, 1925. 409 p.

The author of this book served a long apprenticeship in craft training before he undertook to apply it therapeutically. He also had teaching experience, having at various times been instructor of applied art and design at the Maryland Institute of Fine, Applied, Decorative and Mechanical Arts at Baltimore, and instructor of art metal work and jewelry at the University of Illinois at Champaign. There are few who can boast of such a preparatory period. About a dozen years ago he entered upon his present work as director of men's therapeutic occupations at Bloomingdale Hospital, White Plains, New York, and has embodied the results of his observations during this period in the volume before us. This gives evidence that he is a careful observer who thoroughly scrutinizes his collected facts before he draws conclusions from them.

The book is divided into two parts, the first dealing with the subject in a general way, the second discussing individual crafts, their values and disadvantages. The first chapter is a short historical review to show that occupation has been considered of value in the treatment of mental cases for many centuries. The sedative value of music was shown when David played his harp before Saul. The Egyptians are said to have appreciated the curative value of employment 2000 B.C., while about 172 A.D., Galen said, "Employment is Nature's best physician, and is essential to human happiness." Occupational therapy, therefore, is no new thing, although its exact application is of comparatively recent origin.

The author believes that the first mission of the occupational-therapy department is to create a modified normal atmosphere in which the sick man may spend a certain percentage of his time. The various types of individuals and their idiosyncrasies must be studied. There must be a certain flexibility in applying this form

of treatment, for, as the author aptly says, "Being busy is not necessarily therapeutic."

The selection of crafts and their relative importance are next discussed. Here the author shows that he has been a careful observer. A chart graphically illustrates the conclusions that are elaborated in the text. A balance is shown, the two ends of the beam signifying the maximum and minimum of precautions—that is, those crafts that require the use of no tools and those that require many tools. Hanging from the beam are various crafts at varying distances from the beam and accompanied by a number. These positions are determined, first, by the tool requirement and, second, by the number of patients and variety of needs each craft can meet. For example, basketry lies nearest the beam, as it is believed best adapted to serve a large group of patients and by its variety it can interest and satisfy them. It, however, is third from the standpoint of tool requirement or safety. Weaving is regarded as the safest craft, but is ninth from the standpoint of service. Circular and tennis-net loom work and tennis-racket stringing are also in the ninth position from the latter point of view, although the former is third also as to safety and the latter is tenth. From his experience the author has formulated three questions, all of which must be answered affirmatively if a craft is to be continued. These are: Is it interesting work? Can it be so presented and controlled that the reaction thereto is therapeutic? Can the patient perform four-fifths of all the work involved? Punched brass has been discarded because of its lack of real constructive interest. Floor mats and door mats were discontinued because their making failed to sustain the interest of the patient and required a large proportion of the instructor's time.

Basketry is regarded as the best craft with which to initiate occupational therapy in a hospital because it meets more needs than any other, and is cheaper to install, as it requires little equipment and little floor space and the materials are inexpensive.

A chapter upon the planning and construction of the occupational-therapy building shows the same thought and careful observation as to the arrangement of the different shops. The selection of equipment, tools, and materials and their care are also thoughtfully considered. The department organization, records, relation to hospital service, standards of work, and the reception of new patients are adequately discussed. With a few other subjects, these comprise the first part of the book. The second part treats of such crafts as brush making, chair caning, basketry, metal work and jewelry, enameling, concrete work, tennis-racket stringing, hand forging a silver spoon, and other crafts. Concluding is a description of the author's

ingenious apparatus for bedside occupation and a discussion of the use of crafts upon wards.

Perhaps sufficient has been said to indicate the thorough manner in which the author has covered his subject. It is a book that should be read by every hospital superintendent and especially by those who have not yet provided for occupational therapy in their hospitals. Even those who have will acquire additional information from it. Those physicians whose duty or privilege it may be to prescribe occupational therapy will profit by chapters ten to thirteen, inclusive, although a perusal of the entire book will be worth while. Even occupational therapists of experience will find that it aids in crystallizing their ideas, and it is probable that they may acquire new ones. Occupational therapists of lesser experience—and especially one who looks forward to becoming a director—will find his or her pathway smoothed by mastering the contents of this book.

W. R. Dunton, Jr.

Harlem Lodge, Catonsville, Md.

Dynamic Power of the Inner Mind. By Brian Brown. New York: Doubleday, Page, and Company, 1924. 316 p.

This book purports to be "an outline on Practical Psychology. In simple, direct and plain language, this book gives the basic principles of Practical Psychology, Psycho-Analysis, Mysticism, Metal Science, and Auto-sugesstion."

Any one looking for new or original material here will be disappointed. The book is the usual type of parlor psychology so fashionable at the present time, which professes to explain and solve all the mysteries and problems of life. A large part of it consists simply of quotations from various authors good, bad, and indifferent. To list a few sources, we might mention the Bible, Mohammed, Buddha, Bergson, James, Marcus Aurelius, Coué, Mesmer, Bjerre, Josh Billings, and John D. Rockefeller. The only two important persons who seem to be missing are Bernard Shaw and Henry Ford.

The book starts out in a very pretentious way, taking up the very commonly held conception that the mind has control over the body and is not controlled by the body except as it allows itself to be so ruled. A religious coloring is given to the whole discourse, and there are frequent quotations from religious authors, particularly from the Oriental religions. The discussion becomes rather disconnected at times, and the author frequently seems to jump from one quotation to another without it being quite clear as to why he does so. Perhaps the criticism might be made that the book is mainly quotations, and certainly the author does not hesitate to make up the

bulk of his material from quotations. For example, in the chapter on psychoanalysis and auto-suggestion, the first eleven pages are concerned with the problems of psychoanalysis. Nine of these eleven pages are direct quotations from Freud, Bjerre, Crichton Miller, and Hingley. Doubtless these are excellent authors to quote on this subject, but the work appears at times like a book of quotations.

The author is apparently a follower of Coué and seems to accept his ideas unreservedly. A number of other subjects are brought in apparently with no particular reason unless to show the wide amount of reading the author has done. Three or four pages are given to a discussion of the pituitary gland, and this is dragged in with no apparent relationship to anything that comes either before or after, and without any apparent point to the remarks themselves. An idea of the author's views on endocrinology can perhaps be gained from the fact that in his list of recommended books he gives Berman's *Glands Regulating the Personality.*

To the reviewer the book appears to be merely one more of the numerous attempts of half-baked psychologists and philosophers to deal with the problems of human behavior after the manner of the Pollyanna school. A large number of the quotations in the book make rather interesting reading. It does not seem that the book will do any particular harm, and one might be even stimulated to look up some of the original sources from which the author quotes so freely and liberally.

KARL M. BOWMAN.

Boston Psychopathic Hospital.

OPENING DOORS. By John Thomson, M.D. Edinburgh and London: Oliver and Boyd, 1923. 20 p.

In his subtitle—*A Little Book for the Mothers of Babies Who Are Long in Learning to Behave Like Other Children of Their Age*—the author reveals both the service intended and something of the skill with which the service is tendered to mothers of such babies. This skill is further evidenced by the deftness of his approach to his main subject: "What you can do for the baby."

In the six pages under this rubric he gives practical directions for helping the baby to use his muscles and his will, to form good habits and to avoid forming bad ones, to learn speech and to build his personality.

Dr. Thomson, who is consulting physician to the Royal Edinburgh Hospital for Sick Children, leads up to the training of "babies who behave differently from others" by discussing babies who are blind,

deaf, or crippled, by explaining in a very plain and simple way the reasons for the helplessness of all newborn infants, and by describing the behavior of infants whose nervous systems are developing normally. Thus he comes straight upon the signs of retarded development in infancy, and the direction of his approach makes it easier for the mother to understand both the nature of the retardation and the means by which the baby's development may be favored and facilitated. It emphasizes the slow development of the brain and brings into the foreground the importance of developing the nervous system through the use of muscles and sense organs (Séguin's physiological method).

In these pages we see the pediatrician and the practical psychologist shedding the light of his knowledge of anatomy, of physiology, and of human behavior upon the very puzzling situation of the unhappy mother of an infant who does not behave like other children of its age. By putting his knowledge into simple language he enables such mothers to help themselves out of their unhappiness by teaching them how to help their babies develop. He puts into their hands the means of doing for these babies something that no other person can do because it cannot be done for them after the days of infancy have passed.

Probably the first object of the writer was to economize his own time in the clinic by putting into printed form some of the instructions and explanations that he has found it necessary to repeat hundreds of times. What he has written carries its own evidence that it is the fruit of a long and successful experience with mothers. The book will be found indispensable by physicians, nurses, psychiatric social workers, clinical psychologists, and teachers in their early contacts with mothers of retarded infants. Time will be saved by both the clinician and the mother if sections of the book are read with the mother and marked before the book is given to her. She should reread it frequently as she tries to carry out the instructions given her during the visit. The book is very complete, with nearly two pages of index. It is well printed. It costs only sixpence in paper or 100 copies for twenty-five shillings.

THOMAS H. HAINES.

The National Committee for Mental Hygiene.

NOTES AND COMMENTS

Arkansas

The board of charities and corrections is created by an act of the 1925 legislature. This act abolishes and takes over the duties of ten state boards and commissions which have had the supervision of the state's institutions. The new board is to consist of three members appointed by the governor, with the consent of the senate.

Connecticut

A commission on state institutions is created by Chapter 193, Laws of 1925. The duties of this commission are thus stated in the law:

> "Said commission shall investigate each normal school, state hospital, state-aided hospital, reformatory, and prison and each other institution supported in whole or in part by the state, except public schools, for the purpose of determining the character and the quality of the service of each such institution, the advisability of increasing or diminishing the capacity of any such institution or of continuing support of or the existence of any such institution, and the necessity for the establishment of any new state institution, including the amount of the appropriation required for any such purpose. Said commission shall report to each regular session of the general assembly within fifteen days after the same shall convene."

Florida

The Florida Farm Colony for Epileptics and Feebleminded is placed under the supervision of the board of commissioners of state institutions by a law enacted in 1925. The board of managers of this institution, which was authorized in 1919, is abolished by the new act, which also carries a new provision for court commitment to this institution.

Idaho

In accordance with Chapter 137, Laws of 1925, non-resident persons adjudged insane or feebleminded shall be delivered to the proper institution of their state of residence, provided they have no home or friends to which or whom they can be delivered. If their legal residence is not ascertained, they shall be committed temporarily to institutions for insane or feebleminded in Idaho, until their legal residence can be ascertained. If a resident of this state be adjudged insane or feebleminded while temporarily in another state, and has no home or friends to be delivered to, he shall be delivered to the institutions for insane or feebleminded in Idaho. This law carries an appropriation of $2,000 to cover the expenses of carrying out its provisions.

Iowa

Chapter 187, Laws of 1925, which amends the marriage law, states that the board of control shall furnish quarterly to each clerk of the district court lists of all living persons over fourteen years of age who are or have been inmates of state institutions for the insane or feebleminded, or who have been committed to the guardianship of the board as feebleminded, except persons whose competency to marry shall subsequently have been established by judicial proceedings, or who shall have been discharged as cured. No clerk shall issue a marriage license to any applicant without first satisfying himself that the name of neither party is on the latest list furnished by the board of control. However, any person aggrieved by such refusal to grant a license may institute proceedings in the district court of his county of residence to have his competency to marry established.

Chapter 77, Laws of 1925, authorizes the board of control, among other duties, to arrange for such tests, measurements, examinations, and investigations as are necessary for the proper diagnosis, classification, treatment, and disposition of children committed to its guardianship or to institutions under its management, or for whose care in such institutions application is made. The board must also inquire into the causes of dependency, delinquency, and defectiveness of children, and report to the legislature from time to time any changes in the statutes relating to child welfare that it finds would be likely to promote economy in maintenance and more adequate protection of the rights of children. For the purpose of carrying out the terms of this act, the board is authorized to appoint a superintendent of child welfare. An appropriation of $10,000 is made for the salaries and traveling expenses of this officer and his assistants.

Maine

The 1925 legislature enacted a law that requires the superintendent of any state, county, or municipal charitable or correctional institution to report to the state department of health any inmate about to be released who is afflicted with venereal disease in an infectious form. The state department of health must thereupon take necessary measures to protect others from such infection.

Michigan

Act No. 151, Laws of 1923, which consolidated the principal laws relating to the insane, feebleminded, and epileptic of this state, has been amended by Act No. 283, Laws of 1925. The new law does away with the provision that all medical officers of state institutions must reside continuously at these institutions; allows voluntary patients

to be received as either public or private patients, instead of as private ones (maintained without expense to the state); and provides for the commitment to the United States Veterans' Bureau Hospital at Camp Custer.

An old Michigan law providing for the reporting each year by the assessors of each township and ward of the state of the names of, and various social facts concerning, all insane, epileptic, idiotic, and other classes of persons, has been repealed by Act No. 270, Laws of 1925. The first such law was enacted by the legislature in 1848. In 1873 a substitute law was enacted, which the new law repeals.

Nevada

A backward step in the care of the insane has been taken by Nevada in enacting Chapter 41, Laws of 1925, which contains the following provision:

> "Whenever a person legally adjudged to be insane is deemed by the court to be a menace to public safety, and the court is satisfied that the facilities at the Nevada hospital for mental diseases are inadequate to keep such insane person safely confined, the court may commit such insane person to the Nevada state prison, where he shall be confined until the further order of the committing court either transferring him to the Nevada hospital for mental diseases or declaring him to be sane; provided, however, that no person shall be ordered committed to the Nevada state prison under the terms of this act unless the consent of the board of state prison commissioners shall have been first had and obtained."

New York

The two constitutional amendments mentioned in the July, 1925, number of MENTAL HYGIENE were ratified by the voters of this state in November, 1925. The first one reorganizes the state government into twenty departments, one of which is a department of mental hygiene. The second one allows the issuance of $100,000,000 in bonds over a period of ten years for the acquisition of real estate and the construction of buildings, works, and improvements for the state, including state institutions for mental disease and defect.

North Carolina

Chapter 51, Laws of 1925, authorizes the superintendents of the state hospitals for mental diseases at Raleigh and Goldsboro to transfer to the United States Veterans' Bureau insane patients who have served in the military or naval forces of the United States who are now or may be later committed to the state hospitals.

Ohio

The law relating to voluntary admissions to state hospitals is amended by an act of the 1925 legislature. Formerly the number of such patients cared for in each hospital must not at any time exceed

five. According to the new law, the number is left to the discretion of the department of public welfare.

An act of the 1925 legislature, concerned primarily with the probation and parole of offenders, contains the following new provision:

> "When a person is convicted of any offense, the court may on its own motion direct the department of probation of the county wherein the defendant resides, if such there be, or its own regular probation officer or officers, to make such inquiries and reports as the court may require concerning the defendant. The court may also on its own motion appoint not to exceed two psychologists or psychiatrists who shall make such report or reports concerning the defendant as the court may require for the purpose of assisting the court in the disposition of the case. Each such psychologist or psychiatrist so appointed shall be entitled to receive a fee which shall be fixed by the court and taxed in the costs of the case. All reports provided for herein shall be made in writing in open court and in the presence of the defendant, excepting in such misdemeanor cases in which sentence may be pronounced in the absence of the defendant as provided by law; a copy of each such report shall be furnished to the defendant, if present, who shall have the right to examine the person or persons making the same under oath as to any matter or thing therein contained."

The sum of $250,000 was appropriated by the 1925 legislature as the first payment on the purchase of the property of the Longview Hospital, Cincinnati, which has been owned by Hamilton County and maintained by the state. An additional $250,000 was appropriated for new construction and improvements.

A bill requiring a medical certificate showing absence of venereal disease as a prerequisite for obtaining a marriage license failed of enactment by the 1925 legislature.

Oregon

Chapter 221, Laws of 1925, which amends the commitment procedure in regard to persons who "by reason of insanity are unsafe to be at large", contains the following new provision:

> "In the event relatives or friends, who are competent and able to care for the said insane person, shall request that they be allowed to care for the said patient, either at their home or in a place satisfactory to the court, and if said patient be not criminally inclined or violent, and representations being made that proper care and treatment can and will be furnished to the said insane person and that it will be for the best interests of the said insane person, the judge may, in his discretion, parole the said insane person to the said relatives or friends applying therefor."

Pennsylvania

The 1925 legislature passed a resolution providing for the issuance of bonds to the amount of $50,000,000, to finance the acquisition of

lands and buildings, the construction and improvement of state-owned buildings, and new equipment, for the care of penal offenders, delinquents, mental defectives, epileptics, and mentally diseased persons. Inasmuch as this resolution is an amendment to the state constitution, it must be passed again in 1927, and subsequently ratified by popular vote.

The law relating to the establishment of special classes in the public schools, which provides for the reporting of children between the ages of eight and sixteen who are retarded, has been amended by a 1925 act, to include children between the ages of six and sixteen. The 1925 law also contains the following new provision: "Pupils may also be designated as candidates for special education by mental clinics approved by the Council of Education, or by a psychologist or a psychological examiner who has been certified by the Superintendent of Public Instruction and is employed by any school district." It also provides for home teaching by a legally certified teacher as an alternative, where it is not feasible to provide special-class instruction.

Another 1925 law relating to such classes contains the following provision in regard to state financial aid to these classes:

> "That for each full-time teacher of a special class, and for each full-time supervisor or principal of special schools or classes organized by any school district and approved under legislation providing for the special education of physically or mentally handicapped pupils, there shall be paid to the district, in addition to other payments herein provided, sums as follows: To districts of the first class, twenty-five per centum (25 per cent), and to other districts, thirty per centum (30 per cent) of the minimum salary respectively prescribed herein for elementary teachers in such respective districts; and for each part-time teacher, supervisor, or principal employed in approved special education, a fraction of such amounts proportional to the time for which such person is employed: And provided further, That the total amount paid to any school district on account of any such teacher, supervisor, or principal employed in special education shall not exceed eighty per centum (80 per cent) of the salary actually paid to such person."

An act of the 1925 legislature authorizes the continuance for another two years of the special commission authorized in 1923 to study the laws, conditions, and practices relating to dependent, defective, delinquent, and other types of children. The commission is to report to the 1927 general assembly, recommending such changes in existing laws as seem to be desirable. The 1923 law, creating the commission, carried an appropriation of $5,000, whereas the new law authorizes $15,000 for the purpose of this act.

Act No. 379, Laws of 1925, provides for the transfer to the Laurelton State Village of mentally defective inmates of the State Industrial Home for Women, under certain conditions.

South Dakota

Chapter 219, Laws of 1925, which lists the causes for which divorces may be granted, contains the following additional statement: "In case of incurable, chronic mania or dementia of either spouse having existed for five years or more, while under confinement by order of a court of record, or of the insanity commission as provided by law, the court may, in its discretion, grant a divorce."

Texas

Chapter 76, Laws of 1925, provides for the delivery to the custody of the United States Veterans' Bureau, or other agency or department of the United States Government, of war veterans who may be adjudged to be of unsound mind. It uses the words "of unsound mind" in all places where the term "lunatic" was applied in the law that it amends.

Vermont

A 1925 amendment to the marriage law forbids the issuance of a marriage license or certificate when either party is *non compos mentis.* Before this amendment was enacted, such persons could obtain a marriage license or certificate with the written consent of their guardians or, if not under guardianship, with the written consent of the selectmen of their towns of residence.

Wisconsin

Chapter 394, Laws of 1925, extends the laws relating to the commitment, custody, transfer, parole, and discharge of insane persons in state hospitals for the insane to include the Wisconsin Memorial Hospital. This hospital, whose construction was authorized in 1921, is for the care and treatment of discharged soldiers, sailors, marines, and nurses, who served during the World War and who are suffering from mental diseases.

By legislative enactment the Wisconsin Psychiatric Institute has been transferred from the state board of control to the University of Wisconsin. The board of regents of the university is authorized to equip and maintain the institute as part of the university. The duties of the institute are thus defined:

> "To investigate medical and social conditions which directly or indirectly result in state care; to develop and promote measures to relieve and prevent the need of state care; to undertake special education and training, and generally seek by research and investigation to prevent conditions which result in state care.
>
> "To render a specialized service to the state institutions under the jurisdiction of the state board of control, such service to be available at

all times, to the state board of control, and to the institutions under its jurisdiction. Such state institutions shall at all times be open to the Wisconsin Psychiatric Institute for the prosecution of research investigation.

"To make the Wassermann tests and other chemical examinations provided for under section 46.13 and section 143.07 of the statutes.

"To exercise the powers granted under section 51.235 of the statutes, provided that the transfer of any insane person from the psychiatric institute to any hospital or asylum for the insane, or from any other state or county institution under the jurisdiction of the board of control to the psychiatric institute shall be made only by approval of the state board of control."

The law contains also the following provision:

"There is hereby created an advisory council to govern the relations of the psychiatric institute to the institutions under the jurisdiction of the state board of control and of these institutions to the psychiatric institute. Such council shall be made up of the president of the University of Wisconsin, the dean of the medical school of the state university, the director of the psychiatric institute, and three members of the state board of control. Such council, by majority vote, shall prescribe rules and regulations whenever, in its judgment, these are necessary to govern the relations of these institutions. Such council shall not have power to prescribe any rule or regulation the effect of which would be to restrict the services of said psychiatric institute to the state institutions as provided for in this section."

Wyoming

The 1925 legislature enacted a law prescribing a penalty for the mistreatment or neglect of any inmate of any reformatory or charitable institution, or of any insane person in a hospital or elsewhere.

Annual Meeting of The National Committee for Mental Hygiene

The Sixteenth Annual Meeting of The National Committee for Mental Hygiene was held at the Hotel Pennsylvania, New York City, on November 12. A luncheon, attended by about two hundred guests, was followed by addresses and the business meeting. The speakers were Dr. Charles P. Emerson, President of The National Committee for Mental Hygiene; Mr. Barry C. Smith, General Director of the Commonwealth Fund; Dr. Bedford Pierce, formerly Superintendent of The Retreat, York, England; and Dr. Frankwood E. Williams, Medical Director of The National Committee. Short addresses were also made by Dr. Karl Reiland, Rector of St. George's Church, New York City; Dr. William A. White, Superintendent of St. Elizabeths Hospital, Washington, D. C.; and Mr. Clifford W. Beers, Secretary of the National Committee.

At the business meeting the outgoing officers were reëlected for the coming year: Dr. William H. Welch, Honorary President; Dr. Charles P. Emerson, President; James R. Angell, Charles W. Eliot, and Dr. Bernard Sachs, Vice-presidents; Frederic W. Allen, Treasurer; and Clifford W. Beers, Secretary.

Annual Meeting of the National Council for Mental Hygiene of Great Britain

The National Council for Mental Hygiene of Great Britain held its Third Annual Meeting in London, November 2, at the House of the Royal Society of Medicine. The principal address was made by the Right Honorable the Earl of Birkenhead, Secretary of State for India and former Lord High Chancellor of Great Britain, who emphasized the importance of changing the attitude of the public toward mental diseases. The address, as reported by the London *Telegraph*, was as follows:

"Lord Birkenhead said the angle from which the lawyer examined mental extravagancies or weakness was an altogether different one from the angle of the physician, and it happened that at recurring cycles the physician challenged the point of view of the lawyer. The legal test in such a matter was laid down many years ago in the Macnaughten case, which, he thought, had never received the complete contemporary support of the medical profession taken as a whole, and which had been even more frequently challenged in recent years. He was reminded that at the present moment a Royal Commission was sitting to consider the whole question of the administration of the lunacy laws. It would be obviously improper for him to enter into any discussion of the present legal position, or to express any opinion as to the desirability of an amendment of the existing Acts which would be in effect an anticipation of the recommendations of the Royal Commission. But while he did not anticipate the recommendations of the Commission, he welcomed the opportunity of making it plain that they ought by every means in their power to encourage the curative treatment of persons suffering from mental disorder.

"Such a body as the National Council for Mental Hygiene could play an important part in educating public opinion. They wanted to escape from the old idea of the asylum as merely a place of incarceration. On the contrary, those institutions ought to be regarded as mental hospitals, whose primary function was the treatment of mental disorders of every kind. It had been too long the public habit to look upon an asylum not as it ought to be looked upon, not

as the classical origin of the word would suggest as a shelter, but as being hardly distinguishable from a prison. Such a conception was barbarous and out of date. When once the importance of the curative treatment was realized, it would be understood that the desire which still persisted in some quarters to keep a mental patient out of the mental hospitals as long as possible was entirely prejudicial to his recovery. It was, in fact, to deprive him of the proper treatment at the stage in his disorder at which the scientific treatment was most likely to be successful.

"He was not aware of any circumstances which would differentiate mental from physical ailments, and the influence of the council could not be better employed than by attempting to stimulate a study from the scientific point of view of this grave matter. He had often thought it was a strange circumstance that in the old days it was the habit of the West, which considered itself more highly civilized, to submit those who suffered from mental infirmity to abuse, and even to punitive incarceration, while it was the kindlier habit of the East to offer them an atmosphere consisting almost equally of commiseration and respect. It was a surprising circumstance how difficult it had been both for doctors and lawyers to analyze and collect those varying shades which formed the debatable land between sanity and insanity. The lawyers had quarrelled over it for generations. He supposed even to-day the science and learning upon this topic could hardly describe with precision how slight an alteration in one infinitesimal cell would make the difference between a genius and a lunatic.

"He doubted whether medical science, medical care, and nursing efficiency had made the advance in dealing, from the preventive point of view, with mental cases that, even within his own lifetime, they had made in almost every other branch of medical and nursing science. And yet of all the harassing and terrible consequences that were produced by pathological decline those which affected the mind were at least as poignant and as harassing as those which affected the body. The movement which was founded by an American, Mr. Clifford W. Beers, based upon his own experience, had now attained an international scope, which was the surest source of the hope that the scientific minds of many countries were now considering the problem with a realization of its importance.

"The problem was at every stage beset with complications and anxieties. There was, for instance, the case so alarming of the indiscriminate breeding of weak-minded persons in the community. Just as those sections of the community whose children would contribute most to the welfare of the community had ceased, under the stern

pressure of material stringency, to produce children in the numbers in which their fathers and mothers and grandfathers and grandmothers did before them, this falling off in the most admirable stock of the population had coincided with the maintenance of, if not the increase in, the terrible numbers of children produced by fathers and mothers whose contribution in the nature of things could be no strengthening of the social order.

"It seemed to him the National Council was working on the right lines. It had spent the last year mainly in acquiring precise information as to the resources which we already possessed in this country, and the degree in which they could be improved. He did not know that the reports were particularly encouraging. They seemed to suggest that up to the present it had not been realized that pathology, both physical and mental, was one and indivisible. Until it was generally realized that in disease, whether of mind or body, the problem of treatment had to be undertaken on identical lines, they would not even have begun to master the fringe of this baffling and anxious problem. If a citizen was disabled so that he could not function, if he could not play his part in the domestic and public life of his country, because of his derangement, it mattered nothing at all whether the cause of his disability was a disorder of the stomach or a disorder of the mind. The same processes, humane and healing processes, dictated by wise and prudent research, which many generations had placed at the disposal of our citizens in the case of physical ailments ought equally to be made available in the case of menaces to the mind."

Other speakers at the meeting were Sir Courtauld Thomson, Chairman of the National Council; The Right Honorable Lord Southborough, Honorary Treasurer; the Countess of Chichester; Sir Maurice Craig; and Dr. W. A. Potts.

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PRACTICAL ASPECTS OF PARENTAL LOVE *

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IT HAS been five years since I last spoke before a formal child-study group. The dodging of this issue has not been due to psychic trauma incurred during that last experience, but is definitely associated with reflections arising from some six hundred child contacts made from year to year with dispensary and private cases. In attempting the readjustment of these children, again and again the question comes up, How can one get over to parents and teachers and matrons and boards of managers and directors of religious and social organizations the necessity of honestly following the facts of individual behavior problems, instead of seeking advice to corroborate some cherished point of view? The factors that block the cultivation of such an attitude are not so much limitation of intellectual grasp and educational background as those subtle ingredients of human nature involved in the will to believe. In no other department of medical science is it so hard to educate people with regard to the principles underlying good health as in that branch of our profession which deals with the growth and development and functioning of behavior. This may be due to the fact that for hundreds of years it was customary to section an individual into body and mind, the former belonging to the province of so-called material science and the latter to religious and philosophical speculation. With the rise of psychology, mind became subject to experimental investigation which reduced its facts to something concrete and tangible. Motor and sensory re-

* Read at a meeting of the Chicago Woman's Aid, January 26, 1926.

sponses, the workings of memory, attention, and the association of ideas became demonstrable through processes akin to those already employed in chemistry and physics and physiology, until it was thought that behavior could be reduced quite simply to terms of brain physiology, and, conversely, that abnormal behavior could be explained in terms of faulty brain functioning. We have learned a great deal about the nature and mechanisms of brain structures, to which are being added certain facts about a group of important organs called the ductless or endocrine glands. But the best science of to-day can by no means pin its faith to these two factors as the sole determinants of behavior, for it has been proven beyond the peradventure of a doubt that other factors play an equally important rôle in behavior. Facts of inherited constitutional equipment, facts of environmental influence and early training, facts of disappointment and bereavement and personal conflict, leave scars as devastating to the production of activity as any actual brain lesion known to pathology. Mind and its expression in behavior can be adequately sized up only by investigating *all the facts available* in each individual experiment of human nature, rather than by approaching a person with the unconscious determination to find a cause in keeping with one's own peculiar point of view.

With this background of general facts as to methods of evaluating behavior, I should like to discuss a few common parental attitudes that do a great deal of damage in the way of warping the development of childhood. These attitudes are equally common to all sorts and conditions of mothers and fathers. City and country bred, college and grade educated, foreign born and native aristocrat are equally prone to err when a discussion of their own children is concerned. Each set of parents excuses its attitude of rebellion against the acceptance of plain, straightforward facts by the rationalization of parental love. The only difference of class distinction is that the social stratum with better education and wider opportunities for so-called culture possesses a richer repertoire of defensive mechanisms. Let me illustrate with case material involving parental acceptance of a child who is mentally retarded:

Vincent C. is an Italian boy of twelve who was referred to our psychiatric dispensary because of chronic truancy, petty thieving from market stalls, running away from home for several days at a time, and an impudence and combativeness when he was in school that finally caused him to be excluded as a nuisance. He is one of a fraternity of seven, none of whom except himself has given evidence of antisocial behavior. The father lived for six months at a tuberculosis sanitarium and was then pronounced in fit condition to resume his work. During his absence the family were tided over by a local case-work agency, and the children and mother were carefully followed for tuberculosis—in fact spent a summer at a preventorium.

Vincent has always been stubborn and vindictive. It took him from six years to twelve years of age to reach the low fourth grade, where he stuck fast. The Binet-Simon intelligence test showed that he had a mental age of barely nine years. Obviously the public school had ceased to be serviceable to him, and this particular school had not even the makeshift of a special class. The child's delinquent trends, combined with his serious personality difficulties, made a period of training in a school for retarded children a therapeutic necessity. The mother readily consented, but the father has persistently refused. Offhand, it is easy to ascribe his refusal to an ignorance common in the foreign born with meager opportunities and limited natural endowment. The latter, however, did not prevent Vincent's father from accepting advice to go to a sanitarium himself and to send his children to another civic institution to prevent tuberculous development in them. Yet when the same agency advises him to send one of his children to another state institution where he can get suitable training without cost, this father refuses.

This refusal is based not so much on inability to take in the concept of his child's mental condition as on unwillingness to accept it. Vincent's father is a loud, domineering man who rules his household with a blow and an oath when they do not promptly fall in line. Vincent has always been his favorite child because he has shown what the father considers praiseworthy characteristics of masculine independence inherited from him. The mother and older children have never been

allowed to correct Vincent. When the latter returns from a particularly bad outburst of masculinity, the father thrashes him unmercifully. Though the school has excluded the child and the police have repeatedly brought him home as a vagrant and a thief, the father still refuses to take action in the matter. In doing so he would have to acknowledge his own defeat, give up the cherished and advertised belief that Vincent's crudities of behavior are virtues, accept the fact that they are instead the results of poor mental health, and hence cast reflection on his own brutality of which he has been frankly proud.

Ah, you say, only a psychiatrist, accustomed to setting snares for the innocent, could possibly associate such complexities with a poor Italian mechanic! Perhaps that is true, but suppose we follow parental behavior when confronted with a similar adjustment problem in other social and educational settings. John B. is a child of almost six whose parents asked me to see him because he was "a little nervous and hard to control". Accompanying the request was a letter from the mother in part as follows: "I should like to have you advise me about my six-year-old boy. Three years ago he had a serious stomach attack and now, although he is entirely well physically, he is not responsive enough mentally. He does not converse enough. Though he can ask plainly for what he wants, he has a nervous habit of chattering when excited. He is pleasant and companionable at home, but noisy and unruly in a crowd of children."

With this prologue, I was prepared for anything but the behavior picture that met my eyes on the day of the appointment. Breaking loose from his parents, who were attempting to greet me with their disengaged hands, John darted through the reception room out onto the verandah straight toward a hose in action. When finally captured, he lay down in the water, rolling about, screaming and kicking and striking at his rescuers. Carried to the washing facilities in my office, he threw towels and other movable objects on the floor, tried to eat the soap, and smeared his face with the black paste produced by his washing exertions. At large in my office, he cleared the surface of my desk of everything, including the telephone. In all these performances there was no evidence

of fear or anger or mischief or spite. His behavior represented a pure culture of disorganized and uncontrolled activity without a semblance of purpose or constructiveness. Speech was confined to a few monosyllables uttered with high-pitched intonation. With great effort his parents and I succeeded in holding his attention—and him—long enough to elicit a few responses to the third-year group of the Binet-Simon test.

The mother gave a smooth history of normal development—walking at ten months, sentence formation at two years, complete tidiness, and so forth. The pediatrician later told me that John had shown the opposite behavior since he had known him from infancy—that he was constantly destructive, had pushed his three-year-old sister down an embankment, and had struck other small children with bricks. He had repeatedly urged the parents to bring John for psychiatric examination, but they had refused until several kindergartens had excluded him as a menace.

Naturally my own attempts at helping the parents to insight were also fruitless. They contended that the child was a little excited in coming to a strange office because of the failure of education to teach him properly; what they wanted was a recipe for getting him to learn. Here again, the teachableness of the parents involved the question whether they were intellectually unable to grasp concepts related to the problem of mental retardation in general, or whether they were unwilling to accept these concepts in the case of their own son. Both parents were college graduates and club members. They were well read, and could reproduce the substance of a great deal of literature on the psychology of childhood. They said that they did not believe John to be mentally retarded because he was not like any case they had read of. "And", added mamma, "of course no one can really understand a child as well as his own parents."

After leaving my office sorrowing, the parents consulted a brain surgeon, who refused to perform an exploratory craniotomy. They next consulted an internist, who also called me up to say that he could see no conscientious reason why he should feed this child glandular extracts. The last report is that a tutor has been found to come to the house and teach the child so many hours a week. The mother insists on taking

John about and subjecting him to all the social strains of ordinary childhood.

To understand the mother's self-deception (I mention the mother because she dominates the partnership) one must know something of the background of her own developmental attitudes. She is descended from an old colonial family famous for its culture and literary attainments. One sister developed a mental disorder during which she committed suicide. Brought up in the haunting presence of this family skeleton, which was officially locked in a closet of taboo so far as any family discussion of the matter was concerned, Mrs. B. grew up as an only child. Finances were desperately strained to enable her to go to a fashionable college and make her début at the pace of her set. She was a tense, shy child who had to nerve herself to go to parties, frequently coming home to cry herself to sleep. She felt compelled to live up to the family ideals and ambitions which her widowed mother constantly held before her.

At last she fell in love with a man who was considered a poor match from the standpoint of fortune and social connections. Their married life has been a struggle to keep up a prosperous front. The maternal attitudes of little John B.'s mother are built upon the maternal patterns upon which she herself grew up. Either mother would gladly give the last drop of blood in her body to save the life of her offspring if necessity required, but neither is willing to lower the flag of her conventional standards to follow a course of action that science and education unanimously agree is for the best health of this offspring.

I have presented these two child stories as somewhat glaring paradigms of parental attitudes that are far too commonly encountered by teachers and physicians who attempt to plan for the slow and retarded child. In every public and private school one sees these little folk, restless and irritable and unhappy, trying to live up to parental ideas of achievement. Teachers are coerced to push and prod and threaten and punish, that examinations may be passed and credentials established. Not what the child can do with a sense of encouragement and satisfaction is the watchword, but what he ought to do because he is the possession of his parents.

But mental retardation is not the only behavior problem of childhood that precipitates fundamental qualities of parental love. One of the most serious and common behavior curvatures with which education, social science, and medicine has to deal arises from a childhood combination of intellectual precociousness and abundant physical energy unbalanced by habits of emotional control. Some of you may be familiar with Balzac's story entitled *A Tragedy by the Sea.* It is the tale of a hermit cave dweller who for years had secluded himself on the bleak outskirts of a fishing village in expiation for the murder of his only son. Pierre and his wife were fisher folk, honest, hard-working, and simple in tastes. The little Jacques was a bright, fine-looking lad who easily stood out among his playmates in all spheres of ordinary competition. Parental pride in such a child was natural and would have constituted a tremendous guiding influence in his development had the attitude been rightly handled. But, alas, "one would see them at the fair buying him all the finest toys. It was a folly—every one told them so. Little Jacques soon saw he could do anything he liked and grew up as vicious as a red ass. If any one came to his father and said, 'Your son has almost killed So-and-So!' he'd only laugh and say, 'Bah, he'll make a fine sailor! He'll command the king's fleet one day.' Or another would say, 'Pierre, do you know Jacques has put out Pongoud's little girl's eye!' 'There will be a lad for the girls!' said Pierre. At ten years the young whelp would fight every one he met. 'He'll make a splendid soldier,' said Pierre. By fifteen years Jacques wanted coin, so he set to robbing his mother, and she didn't dare say a word of it to her husband. At last one day while his father was away fishing, the son carried off all the furniture in the house and sold it to go on a spree. When Pierre came back and heard the tale he said, 'He's too fond of his larks.' Six months went by and Pierre goes to plead his son's cause before a justice. But he doesn't ask him, 'What hast thou been doing?' He only says, 'If thou dost not stay here for two years with thy mother and me, and keep thyself straight, and go fishing and live like an honest man, thou'lt have me to deal with.' The mad fellow, counting on his parents' folly, makes an ugly face at his father. Thereupon Pierre gives him a cuff on the side of the

head that lays up Master Jacques for six months." Then comes another robbery, and Pierre, in a moment of rage born of wounded pride, drowns his son in punishment of behavior for which he, Pierre, alone is responsible.

But one need not go to literature, except for the authority of tradition, to realize that the story of little Jacques is based on facts that occur as frequently in the year 1925 as in the days of Balzac. Every community has such adolescent wreckage drifting through its courts and correctional institutions, clogging the wheels of its industry, and filling beds in its hospitals. Here are young people, with bright minds and healthy bodies, succumbing to the simple requirements of ordinary social organization by reason of habits of aggressive irresponsibility learned at home. In that atmosphere of early childhood the boy or girl soon catches on to the fact that because he or she is clever, or handsome, or surrounded with social prestige, he or she does not have to conform to courses of action expected of other children less fortunately endowed. Rude and domineering to servants and playmates and parents, there is no logical reason why such a child should not behave likewise to teachers and employers and business associates. Golden Rule teachings, attendance at Sunday School, lessons in manners, cannot and do not neutralize the effect of daily getting away with slipshod responsiveness through a stock in trade of such excuses as, "I forgot", "I didn't understand", "I never heard you say so", and so forth. Then comes a deliberate and flagrant example of bad faith, and the mother rushes for medical aid, with the fear that the child is beginning to show a change of personality, perchance due to brain pressure from a fall at two years of age! Reconstructing the parent-child and inter-parental relationships year by year up to the point of the supposed personality change, one invariably finds facts which show that the child's behavior reactions have always been consistently in keeping with the policies adopted in his management. Let me illustrate with two sketches of case material, again taken from different walks in life.

Ronald is ten years old. His mother came to us with the complaint that he is quite beyond his parents' control, and she feared that in another year it might be necessary to send

him to a correctional institution. So far he has done nothing worse than quietly ignore every request they make of him.

"It has come to the point where I can make no impression on the child unless I tell him that he is breaking my heart and killing me by inches. Do you think his mind could be affected?"

The immediate cause for psychiatric emergence was an occasion when he was forbidden to go over the way and play with a boy whose mother was entertaining at luncheon and would be disturbed by the noise. Ronald said, "Yes, mother", diverted her attention to another part of the house, walked out of the front door, and was seen no more till 4:30 p.m., when he came back in time to take his place in the limousine with a group of children his mother had invited to a moving-picture party. The mother did not deny him this outing because she thought it would be bad psychology to shame the child before his playmates. That night at bedtime she cried, told the child that his eight-year-old brother wouldn't have been so disobedient, and said that she would discuss the misbehavior with the father, and if he thought it worthy of a whipping, such punishment would be administered by father. Instead of weeping as usual, Ronald exclaimed, "I hate Bill, and I don't give a damn for you or Daddy either!" Next day the family took the train for Baltimore.

The father is a hard-working business man who feels that his job in the matrimonial partnership is to furnish the wherewithal for the maintenance of the present and the inheritance of the future. When he comes home after a day's work, he wants the atmosphere free of friction. Consequently he is irritated if called upon to act as judge and executioner, and Ronald not infrequently hears the domestic discussion that ensues before his case is called before the parental court. The mother's governmental policies have always consisted of arguing the pros and cons of every request, of issuing threats that are never carried out because when the moment arrives the child cries and she weakens, and of comparing Ronald with Bill, who is younger and less alert and energetic. The father's idea is to make few requests and see that they are fulfilled, but he goes through the rôle assigned him as patiently as he can in order that he may not give the mother a sense of failure

and destroy the ideals of parental harmony which both parents have always fooled themselves into believing exist in Ronald's mind. In talking with Ronald it becomes evident that the lad is well aware that his father thinks poorly of the mother's methods of training and administers punishment only because he is asked to do so. Here is a young offender living under a government of rules to which he has subscribed as reasonable, but consistently failing to perform a single jot or tittle of those laws without constant supervision. Parental love in this family is quite secondary to inter-parental relationships. It does not require imagination to picture what troubles are in store for parents and child in this household when at ten years their oldest son declares with an oath that he has no respect for either one of them. Can one blame him for not swallowing ethical principles and platitudinous advice from father and mother who do not love him enough to get together frankly on the policies of his training?

George S., aged seven and a half years, was brought to our psychiatric dispensary by his mother with the complaint of "violent attacks of temper, stealing toys and pencils and money, drawing vulgar pictures and passing them in school! Could this be from pressure on the brain?" The child proved to be in excellent physical condition, and had a mental age of 9 years, according to the Binet-Simon test. Obviously the behavior difficulties could not be ascribed to physical or intellectual handicap. Four years before, the mother had divorced the father on grounds of "incompatibility". The husband, she said, neither drank nor was abusive or unfaithful. "He was just too stingy to live with." The mother is a graduate of a teachers' training school, taught prior to her marriage, and has been teaching since her divorce. She has always taught first and second grades because the discipline of older children was too much for her. During marriage she never wanted children.

Since the elimination of the father, the child and his mother have lived for the most part in boarding houses, because the mother claims that her sisters are too critical. George slept with his mother, sitting up as late as she. He was usually the only child in the boarding house and the aggressive center

of attention. Every wish for candy, toys, ice cream, and so forth, was gratified. Entered at six years in one school, George was transferred to another because he was found to have taken a knife and other trinkets. The mother defended the child in his presence. On transfer to a second school he took a watch, and was transferred to a third school. When crossed in any request, George would lie down on the floor, scream, tear his clothes, and spit. For this conduct and the stealing, the mother had, nine months before coming to us, taken him to another local hospital where he was circumcised, without benefit to his behavior difficulties.

Our clinic explained to the mother that the child's stealing and lying and tantrums were not trivial matters, but serious antisocial trends that would gain momentum with every year of neglect, that her defense of the child by transferring him from one school to another was a fatal step in management. We urged that she place the child in a good school outside the state, where he could get a fresh start in a more wholesome environment, and that she leave him there, except for holidays, until he had grown sturdy roots of better behavior reactions. She appeared to acquiesce in these plans, visited the school selected, and placed the child in it. At the end of two months we received a letter from the principal, stating that the mother had appeared and taken the child away, excusing her action by picking flaws in some institutional regulations that the child had been obliged to follow.

Six months later the mother appeared saying that the child was again in difficulties. She was quite unwilling to acknowledge herself at fault in removing him from this last school venture, declaring that he was homesick and too young to go so far away from "a mother's care". Here is a mother who has kept up in education, is well read on child psychology and the literature of the pre-school child, and is a regular attendant at lectures on child study. She can apparently apply these principles intelligently to other people's children, but is completely lacking in realization of their significance in the case of her own. Is she blocked by inability or unwillingness to face plain facts that are evident to everybody but herself? As we look back over her life, we see that she has always

been accustomed to meet vital personal issues with the same process of rationalization she is using now. She deliberately brings up her child fatherless because she cannot live with a man who is "mean and stingy"; she cuts herself off from sisters who would gladly make a home for her because they criticize her for spoiling her child. With such habitual attitudes of self-deception, can we expect this woman of forty-five to acknowledge her complete failure in the management of her seven-year-old son? To her pride will be sacrificed the happiness and future usefulness of this bright lad. And medical science and education are helpless in the matter.

Among the varying degrees of childhood normality bubbling up in behavior problems is that of the child who early shows aggressiveness in antisocial trends that are far more deep-seated than spoiled-child reactions and unassociated with mental retardation. Here are children who from the start need expert guidance and the benefit of every help that the best in medical and social science has to offer. Even with all this, their adjustment is difficult enough, but when constitutional psychopathic trends are saddled with parental obstinacy, these children invariably go to pieces on the rocks of adolescence.

A case in point is that of Martin F., who was referred to our Phipps Psychiatric Dispensary in 1919 by the county board of education, who had expelled him from school for twice holding up the teacher with a gun of which his parents refused to deprive him. The mother brought him to us, she said, because she considered it politic to do so, not because she had any intention of following the suggestions we might give her.

Although only ten years of age at that time, Martin had a long record of progressive incorrigibility. At two years of age he ran away from home and was found in an engine cab at the railway station. At three he took a revolver and amused himself on occasions by chasing small children in the neighborhood. At four he got a newspaper write-up for throwing bricks through the windows of a house whose owner had offended him in some trivial way. From five to nine years he had been picked up by the police six times at distances of from twenty to forty miles from home. Our examination,

at ten years, showed an intelligence quotient of 120, plus good physical health. This was all the mother would allow us to do.

Five years later the lad was transferred to us from a psychopathic hospital in a neighboring city where he had been taken following his arrest while stabbing a sailor in a drunken brawl. His record during the interim between our first and second examinations was in part as follows: six admissions to various correctional institutions; three boarding homes under supervision of a welfare association; court assignments to the Big Brother League, the Bureau of Labor and Statistics, a county children's aid society, and a Catholic school. No sooner was he placed in each of these spots than the mother instituted legal proceedings to have him taken back to court or placed elsewhere. Meantime she visited him as often as possible, telling him that he did not have to obey the rules or follow the directions given him. Even while the boy was on our psychiatric house service, she took advantage of the fact that he was not legally committed to us and, picking a quarrel one night with the physicians, removed the boy at 10 p.m. to her own home. Six months later he attacked his father with a carving knife, for which he was committed to one of our state hospitals. Martin is still on their disturbed ward, in such a condition that even his mother does not dare to attempt his release.

The family background of environment and training in this case is not without significance. The father is an excellent mechanic who earns steadily and saves his wages. He has left his wife several times for reasons which neither cares to discuss, but always returns to give her his hearty support when she has declared war against a third party. The mother is a high-school graduate, well read in history, law, and sociology, and able to quote Shakespeare readily. This couple have deliberately brought up Martin and his older brother and sister to be individualists in their relation to the rest of society. For example, they have been taught from early childhood to believe that the world owes them absolute freedom to live their own lives as they choose, that rules and laws need not be obeyed unless they suit the wishes of the individual. Naturally all these children have been continually in

conflict with school and neighborhood and employers. They are without friends or community social contacts. With every year of conflict and its inevitable defeat, they become more bitter and erratic in their behavior.

The parents of these children are not psychotic, but desperately in need of mental hygiene. They pick from the latter what they need to justify their own point of view, and then discard its constructive aspects as soon as a legal defense has been established. All the educational influences in the state have been unable to keep this mother from forcing her children to grow up as grave social misfits. Year by year, through her philosophy of a spurious freedom, she drives these children into a slavery far more fatal than the atrocities reported from Africa. And every time she has gone into court to regain the right to mismanage Martin, she has diverted magisterial sympathy from magisterial judgment by using the plea of "a mother's love".

In presenting these cases for your consideration, I have not gone out into the byways and hedges of dispensary and private practice to cull the rare and exceptional, but have described material that in my own experience represents a common, garden variety of the family situations that make the adjustment of the problem child so difficult. There is probably not a person in this room whose life has not been shadowed in some way by unwholesome parental attitudes. Take the matter of adolescent emancipation, for example. Fifty years ago it was considered pathologically unnatural for any daughter to refuse "to see her parents through". This meant that she gave up hopes and ambitions and plans and resigned herself to a program that year by year became more drab and circumscribed. In middle life she found herself alone in the ancestral home, surrounded by faded heirlooms and devoid of friends, who had long ago been obliged to leave her behind in the journey of life. Or there is the daughter who was told she could marry only on condition that she made her family life beneath the parental roof. Or there is the son who struggles for years to run the family business according to methods his father found successful in 1888. Should these uncanonized saints rebel and attempt to live their own lives, terrible scenes ensue. I know a sixty-

year-old father who went to bed and stayed four years because his thirty-year-old son moved to a neighboring town in order to carry on his business to greater advantage. A clever and brilliant teacher of forty-two wrote me not long ago, "I should like to come down and visit you, but mother makes such a fuss when I leave her, and always does something to make herself sick." This woman has been separated from her mother only during her four years at college, and even then that devoted parent hounded her with daily letters saturated with accusations of neglect and selfishness. A telephone employee, superintendent of a city exchange, told me that at thirty-two years of age she had never bought a pair of shoes for herself. She didn't have the courage to select her own clothes because of the storm of ridicule and abuse she would receive from her mother. To meet the conflict of this family situation, she became a headache invalid. I have struggled in vain for six years to persuade two intelligent and genteel parents to allow their two daughters of thirty-odd years to have checking accounts. These dear old souls still follow their children to the front door with rubbers and measure out their cascara at night.

In attempting to salvage this adult wreckage, the physician is again confronted with facts of selfishness, jealousy, self-pity, and spite reactions complacently rationalized in the phrase "parental love". In common acceptance the love of parent for child is considered the highest form of affection in human relationships. And so it is in many an instance, rising to all the heights of sacrifice and self-forgetfulness portrayed in the poetry and prose of centuries. It is the very fineness of these qualities as they can express themselves in the parent-child relation that makes it so important for parents to cultivate the habit of being honest with themselves, to temper mercy with judgment, to differentiate between guidance and tyranny, to avoid making childhood the butt of grown-up emotional immaturity. This is a large order for the serious and conscientious parent of to-day to fill. Added to the complexities of daily living thrust upon the shoulders of every household, there are floating about in our midst a great many recipes for parental guidance in child development. For example, all sorts of people are talking about the

dangers of repression in childhood. Popularly interpreted, this means that every impulse that flits across the consciousness of childhood should be allowed to express itself without adult interference. If this is not done, children will rise up against their parents, and we shall have a new kind of warfare in the story of civilization. Now it is perfectly true that individuals become ill from the festering in their personalities of all sorts of warped viewpoints and unhealthy experiences which need the drainage of ventilative discussion. It is equally true that much of this infectious material is acquired in the periods of childhood and adolescence. But granted such facts, it certainly does not follow that the prevention of this damage is to be found in thrusting complete freedom of choice upon mechanisms of judgment and control in their most immature stage of development. One has only to look at the chaos that results when the feebleminded are confronted with adult responsibilities to see where the doctrine of license in childhood would lead its disciples. Are the greatest childish pitfalls to be found in repression or in the mismanagement of guidance? It is so easy to be baited by catch phrases of common psychological parlance and to spin them out upon the surface of our minds without ever really pausing to think them through. "Inferiority complex", "repression", "father or mother fixation", "psychoanalysis" abound in our vocabulary with the phraseology of mah jong.

What do these words mean, not as expressions of abstract concepts, but as applied to the difficulties of our own lives? Suppose a group of mothers, banded together for the purpose of child study, should give up their lectures for one season and devote themselves to a serious study of some of the behavior problems found among the small inhabitants of their own households. Among the topics for informal discussion could well be included methods of handling jealousy between brothers and sisters; the management of crying and anger tantrums; the facts associated with indifference to school work; variation in responsiveness to father and mother; the acquisition of a healthy balance between over-stimulation and the satisfaction of normal cravings for amusement and recreation. Parents of every household have to meet these issues in some form or other, and as yet there have been collected

practically no data from the standpoint of their observation and experimentation in such matters. A year's intensive study along these lines, with meetings from time to time for suggestion and guidance from some able adviser, ought to prove of inestimable value to mothers who really want to understand their children. (I mention mothers because in the majority of homes the burden of training falls upon them.) The understanding of children is not a gift that naturally accompanies the maternal instinct; neither is it accomplished by the cultural process of keeping up to date on all the literature dealing with child study. Each family constellation is an entity in itself, requiring specific variation in the application of any social and educational principles to its needs.

I am well aware that such a program of study as I have outlined calls for a frankness of self-analysis that is not easy. It will not appeal to mothers who sit on managing boards of child-welfare organizations and correctional institutions and yet shy at bringing their own children to the office of a psychiatric adviser because of the supposed stigma attached to the procedure. I recall such a light in our own community who came to my office in almost detective disguise to tell me about her twelve-year-old daughter who three times in one year had hidden her mother's favorite diamond ring, finding it each time at the end of a week's search in order to bring herself into the limelight of maternal interest and approbation. Here was a child who resented all the social and community activities that kept the mother from paying more attention to her, and she hit upon a scheme to make herself prominent in the family circle. The activity in itself was not pathological, but to a less complacent parent would have constituted a danger signal that would have compelled her to pause in her civic good work and study the adaptation of her own child. The parents of to-day do not need more light, but more courage to follow the light that they have. The healthy adjustment of childhood does not depend upon physician or psychologist or teacher, but upon the atmospheric conditions of the home. Science and education are but the handmaids of parental love, and as servants they cannot be above their lord.

MENTAL HEALTH IN CHILDHOOD*

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THE IMPORTANCE of mental health as a factor in the efficiency of an individual—whether it be in his contacts familial, educational, industrial, or social—is becoming recognized more forcibly each year. When one stops for a moment to survey the progress made in modern psychiatry, even in the last decade, one is impressed with the evidences of dynamic, forward-looking activity. In the past, our efforts were directed largely toward an ever-increasing refinement of technique for the classification and diagnosis of nervous and mental ills. As our understanding of these problems of mental maladjustment progresses, we are discarding to a degree our more static concepts of disease entities, and are attempting more and more to understand all the elements within the individual and his environment that have played their part in creating the kind of problem which he brings to us. For only with an understanding of all the elements that have played a part in shaping the whole life experience from babyhood up can we interpret adequately the behavior reactions of the individual.

Behavior has a purposive value for the person, whether that behavior be good or bad, moral or immoral, healthy or unhealthy. The acceptance of this fact demands that an adequate study of the whole range of experiences of the individual be included before we can attempt to evaluate any given difficulty.

In adults as well as in children combinations of behavior reactions recur so frequently that it is possible to classify these symptom complexes under diagnostic headings, but to get results through treatment we cannot treat the disease entity of dementia praecox, manic-depressive psychosis, or other diagnostic categories. We must, however, concern our-

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selves with the dissolution of some of the destructive emotional, physical, and environmental combinations involved in the state of unadjustment. Through the period of treatment, often prolonged, attempts are made to reintegrate the elements in the personality of the individual. This process of integration—if it can be carried far enough—may make for a reëstablishment of normal relationships within the individual himself and between him and his environment. As an illustration, in the following case a diagnosis of praecox could be made, for the boy of eighteen is unable to hold a job and has become increasingly unreliable, quarrelsome, and suspicious, often threatening his employers because of imagined mistreatments and partiality shown to the other employees. In conversation he talks freely of his imagined wrongs and describes in detail his plans to get even with the office boys, the head clerk, and so forth. The office force as a whole, he feels, is down upon him. He frequently overhears telephone conversations which he is sure concern his own private life. He has detected meaningful glances between individuals as he enters a room suddenly and occasionally has found sentences in letters in the outgoing mails which, he believes, apply to him. He admits that he is altogether miserable and unable to do his work satisfactorily because of his preoccupation with his worries, but beyond this he has no real insight into his difficulties.

To discharge him offers the firm a release from irritation. He will carry to another job, however, the same set of attitudes, predetermined by his own unhealthy emotional problems, and the same cycle of irritations, culminating in the loss of the new job, will occur. To place him in a hospital for the insane will protect society from any destructive attempts that he may make in his desire to get even with or to destroy his persecutors, but this, too, is only a protective measure and has in itself no positive curative values.

A study of the boy's background reveals some suggestive facts. The youngest of three children, he was always the mother's favorite. The early developmental period was punctuated with many illnesses, which necessitated a good deal of the mother's attention. Because of a heart condition which may have been the result of a severe attack of measles

at one and a half years, the mother did not feel free to wean him, and nursing was continued until after the age of three. Weaning was a distressing experience for both mother and child. While the mother attempted to find appetizing foods, he steadfastly refused to partake of anything but liquids. To the present day his diet is chiefly of the liquid and semi-solid variety. At the time of this illness the mother slept in the room with him and this arrangement continued until the boy was seven, for each time she proposed going back into his father's room, he developed night terrors or such severe crying spells that the separation was constantly deferred.

At the age of seven the family doctor finally told both the boy and his mother that this must stop. Accordingly the mother left him to sleep alone, but the boy developed sleeplessness and frequently complained of an inability to breathe. The attacks of difficult breathing were diagnosed as asthmatic and were referred to the original cardiac condition. During the asthmatic episodes, the boy developed the habit of wandering into his parents' room, for, as he said, "There is only one window in my room and there are three in yours." The visit to the parents' room usually resulted in his getting into the mother's bed and, this objective attained, he could sleep peacefully until morning. At school, because his mother felt that he should not be exposed to undue strain, he was privileged to leave the room without permission. She accompanied him each day to carry his books and met him at the gate at the end of each session. Normal play interests were denied, for there was some question of the effect upon the heart condition. Occasionally, he was challenged by some boy to fight or the fellows picked on him in line. Each time, however, he ducked and ran, and when the irritation got too great, his mother would visit the offender's mother, or, on occasions, she would administer a beating herself. She decried fighting, and the boy recalls that many times she said she would rather have her son dead than have him fight.

The boy's school progress was rapid because of the help which the mother gave him in the hours of effort that went into preparation. At fifteen he graduated from high school and a college career was planned. The summer after graduation, however, his father died and it was necessary that he go to

work. There was no chance to think of the inadequacy of preparation which his fifteen dependent years of experience had created for him. Never having had to face reality unprotected, he must now meet the pressure of a job and the competition of his fellows on his own, with no maternal protection. Never having had to face the display of authority, he must now conform and without questioning. His sensitive, shrinking efforts seemed to irritate his employer, and after a call down, his work became even less effective, the harshness of the criticism increased. The duration of each job grew shorter and shorter, until at the time the boy was brought for study, only temporary jobs were available. To each he made application as if it were his first employment, not only because the references from places from which he had been discharged were no good and the jobs from which he had run without notice could not be mentioned, but because he felt vaguely that the system of persecution was gradually becoming more complex, and on several occasions he felt that questions put to him by his prospective employer seemed to point to previous information about him.

It is not hard to see some of the cause-and-effect relationships in this lad's problems. The childhood filled with overemphasized dependence, the prolonged infantile habits of gaining satisfaction, the over-protected atmosphere, and the boy's own attempts to hold on to the infantile patterns of behavior, even though he had reached adulthood on the physical and intellectual levels, suggest the complexity of the adjustment problems that a job in the competitive industrial world must have created for him. It is not difficult to see how, in his stormy course from one job to another, in contacts with irate employers and playful office boys, the lad frequently felt insecure and harassed and was conscious of a need to seek protection. Although he had never in the earlier years been permitted to fight, the wish to get even struggled to come through. The ineffectiveness of his punch on several occasions—with the painful results of a stiff beating from the other fellow—his sense of chagrin, and the never-ending guying, produced increased irritations. To lose his job meant no income for the family, since his mother was not well and his two sisters were married and busy with families of their

own. To fight was impossible. The brooding, his own feelings of hurt pride, and the constant pressure gradually effected the change that brought him for study as a mental case.

Treatment must first bring release from irritation on the job, and so an employer who could understand was found. The period of adjustment was stormy, punctuated with many "blow ups" from the boy. The fact that there were few employees and that he was responsible only to his employer made these outbreaks less destructive to him. On the social side, an attempt was made to tie him up with a group with whom he could compete successfully. A debating club interested in politics and world issues offered an outlet with a chance of success. He had won a medal at debating while in high school, so this step was fairly easy for him to take. It was in relation to the deeper emotional problems that most difficulties were found. The reason for this is obvious when we note the deep infantile attachment which never had been relinquished. To relate the details of the material that came to the surface, while most interesting, would be too time consuming, and at this point we are concerned with the results. The objective of treatment in all cases is to make possible the adjustment of the individual at a level simple enough in its demands to make successful adaptation possible. In all cases the rapidity of progress toward this objective will be determined by the capacity of the individual. However, at this point, we reflect that in treatment of this boy we are supplying him with opportunities for functioning in a protected environment; in other words, we are in the beginning assisting him to regain his sense of security in a setting where he is understood and has plenty of opportunity to succeed.

Whether cases of this nature manage to work out a program of adjustment for themselves which leads to a gradual relinquishing of infantile patterns of satisfaction is a matter of individual adaptation. The best road to mental health in adulthood is by means of sound integration of the physical, intellectual, and emotional growth in childhood. As Dr. White has so aptly said, "Childhood is the golden period for mental hygiene." The emotionally determined habit patterns of reaction may lead to continuous growth and emancipation

from the infantile level or may tend to foster, even into the period of adulthood, patterns of response that produce for the individual infantile security and protection.

By mental health in childhood we imply that the child be furnished opportunities for growth and development of his personality as a whole. It is not surprising, then, to find in our program of prevention more and more emphasis on the beginning period. To give each child the right to grow and develop within the limits of his own ability is the birthright of each new-born baby.

This period of babyhood, in which the child is dependent upon the grown-ups in his environment for care and protection, offers many opportunities for mishandling by the parent or nurse, who thinks of the child as having only certain physical needs apart from the emotional values which this kind of care is bound to promote. We are all familiar with the spoiled baby, who cries to get what he wants when he wants it.

If a physical problem appears on the horizon, as it is prone to in childhood, the emphasis of the parent is frequently directed towards the one objective—to get the child well again at all costs to herself. The child who gains a sense of satisfaction from holding the center of the stage is bound to find it hard to relinquish it after the physical difficulty has disappeared and is prone to continue tactics designed to renew the pleasurable experience. If the mother could but visualize the ramifications of emotional response that can develop sometimes with but slight provocations, and the essential destructiveness of the results for the child if these unhealthy patterns do get established, she would seek in her methods of care the same objective, but with a healthier emotional component for the child. This includes even the simple problems of everyday experience, such as weaning, the establishment of habits of eating, sleeping, defecation, urination, dressing, and undressing, self-reliance in all things, contacts with strangers, and the many other issues which are a part of each child's existence. An objective, friendly, uncritical attitude is the first prerequisite for putting into effect this schedule. Perhaps lack of understanding of the importance of such an attitude may make the task more difficult, or an inability on

the part of the grown-up, due to emotional limitations of her own, as was the case with the mother of a nine-year-old red-headed boy whose continuous "monkey actions", as the mother put it, drove her distracted, until finally it was necessary to "lick him just in order to get satisfaction for herself, because when she got so mad just to beat him good helped her to cool off".

It is difficult always to remember that these children are like sensitive pieces of litmus paper, strangely capable of sensing the emotional elements present in the parent, even though verbally unexpressed. The gradual ability of a child to dominate the situation and gain the satisfaction of ruling the mother, and incidentally the rest of his small world, is evident in Bob, aged four. He is the only child of a fond pair of parents and the only grandchild of two pairs of grandparents. His birth was normal and he nursed until he was three months old. At that time the mother developed influenza and was ill a week. Bob was given a formula. While he took the food, it was always with a struggle. In spite of the combined efforts of the family doctor, his aunt, the father, and two grandmothers, he would manage to fight and cry so, each time that an attempt was made to feed him, that he got away with taking less than the normal amount. The result was a rapid loss of weight until, by the time the mother recovered from her illness, he was seriously depleted. Because he was hungry he cried constantly, although when given food, he refused it. No wet nurse was available, so the mother gave up her entire day to caring for the boy. Holding him in her arms, she walked the floor or rocked him and, even though he fell asleep, the moment she attempted to put him down to rest herself, he wakened and would scream again. This performance kept up for two months. Finally, after he began to get other food products, he showed a gradual increase of weight, but his demands for his mother's presence still continued. He must always be where he could see her. Even at night, she must hold his hand until he slept. Because the mother did not stand the confining program well, the doctor felt that some relief had to be gained and began a course of bromide for the child. This bromide medication had been given continuously for two and one-half years before the child came for study.

The cause that precipitated reference to a psychiatrist is extremely interesting. Three weeks before the child was referred, he had begun to have what seemed to be night terrors. He would waken in the night screaming, attempting to push something away from him, and to all appearances was in a state of real terror. The only way the mother could quiet him—and, incidentally, keep the family from being evicted from the apartment house—was to take him into bed with her. He was not satisfied until he could get fixed in one position. His body had to be entirely upon hers, with his head buried in her neck, his arms crossed, his trunk resting upon her chest, and his legs doubled up, the knees in the pit of her stomach. In this position he would fall asleep, but, if in the relaxation of sleep, a leg or an arm would fall away, he would waken again in loud terror and scream for another hour or two. The mother, terrified for fear her child was becoming "crazy"—for a diagnosis of "nervous child" already had been made by the family doctor—was a very ready coöperator in treatment. Here, again, we see in the child's four years of emotional experience certain methods of gaining satisfaction that could not do otherwise than bring disaster sooner or later. The fact that the boy is only four and that these patterns are not so deeply fixed makes the process of adaptation simpler. When we look for the attention-getting devices this baby has worked out, we realize how complete his final gesture is: the wish to be mother's baby and to possess her completely is finally accomplished quite successfully in the night-terror episodes—and at this point it is not necessary to say that the boy wasn't the only one who was in terror.

To accomplish with this boy a willing acceptance of the weaning process at the age of four is more difficult than it would have been at three months. The more common advice of the pediatricians to include one bottle each day from birth is a wise safeguard to assist the mother in helping the child to accomplish this giving up of mother satisfaction. That there is emotional value for the child as well as for some mothers in the actual nursing experience is a recognized fact. It is possible in this child at three months to see to what degree he placed a value upon it. The fact that he was the first child and had held the center of the stage before this

experience complicated issues, no doubt. Certainly, the subsequent intensive care and the worry assisted him in gaining attention. From his birth he had furnished the axis about which the life of his family revolved. It is not surprising that a complete kind of satisfaction of this sort could not be relinquished without a struggle.

The program of treatment in children of this age is best carried on through the education of the parents. Bob's mother, like most other mothers as emotionally tied as she, found some of the plans far from easy of execution. Perhaps if she had not been afraid of the possible seriousness of continued night terrors, her coöperation might not have been so good. It was pointed out to her, first, that she must help the boy free himself from his dependence upon her. This could be accomplished only by her willingness to let him grow up, which, she admitted, wasn't easy. To help him find satisfaction in feeding himself, dressing and undressing, going out with his father, thinking of himself as a big boy, doing things because he was a man instead of mother's baby, attaining the dignity of being called Bob instead of "Baby", going to bed without holding mother's hand until he fell asleep, and so forth—these are some of the many patterns of reconstruction used, each in itself having little value, except that the handling which the mother and other members of the family gave it tended to wean him from infantile satisfactions to the point where he could place positive emotional values on the growing-up experience. To accomplish a completely healthy integration requires time. But, from the day the mother changed her own method of handling, the boy began to improve. For the past six months there has been but one attack of terrors which was slighter than the rest and which occurred two days after the first visit; he has taken no bromide or other medication, sleeps in a room by himself, dresses and feeds himself, and this last month has become a happy member of a nursery-school group. These facts, surely, suggest that he is gaining some satisfaction from growing up.

The readiness of response to wise handling in the early years is obvious, and the possibilities for building wisely for the future, if healthy programs are created, is assured.

The subject of mental health in childhood is a big one, for,

even in this process of growing-up, so-called, there are many problems of adjustment involved. The cases cited in some detail suggest a few of the many pitfalls that we must guard against.

If we recognize that every experience of a child, as of an adult, has for him an emotional or feeling value, we shall see at once that each new contact, whether it be simple or complex, has for him a positive and satisfying or a negative and unsatisfying value. Whether these feeling responses are satisfying or unsatisfying, constructive or destructive, is determined by the needs and wishes of the individual, although the emotional determinants are admittedly not always consciously present in his mind.

To determine whether or not the satisfying experiences are constructive—in other words, whether the resulting response leads towards a gradual growth of maturity and integration for the individual—or whether they are positive and yet destructive—this should be our greatest concern. By regressive tendencies we mean those reactions to any given experience or group of experiences which tend to foster continued dependence—the clinging to infantile attachments—and in the main are more regressive in their value than progressive. Prolongation of infantile dependence in the many ways in which a child is prone to accomplish it not only interferes with normal growth and emancipation during the childhood period, but is prone to be carried over into the problems of adult life.

The many factors involved in the life experience of the child offer us fertile fields of study—the mother-child relationship with all of its manifold issues of dependency, habit formation, and growth; the father-child problems in which the child must establish an adjustment to the paternal source of authority; the parental-child relationship with its irritations, jealousies, and the like, which must be met; the problems of parental relationship with other brothers and sisters, with their competitions, jealousies, and struggles; the school adjustment with its responsibilities of social contact and educational effort; and the hundreds of other problems in the daily schedule of the growing child.

As was implied, the attitudes and patterns of behavior on

any occasion or in general are determined by the emotionally colored experiences which have played their part, from the time life began, in the creating of the fabric of personality. The healthy growth of the personality is accomplished only when the daily handling which the child receives in his environmental setting and his own personal reaction to this handling each day lead to a progressive weaving together into a complete and mature whole of his experiences, physical, intellectual, and emotional. The sum of all these experiences, worked into a pattern of increasing complexity and richness as days multiply into months and years, leads toward a state of normal mental health which should be the privilege accorded each and every child.

It is only when an appreciation of the values of mental health in childhood becomes more widely disseminated among physicians, parents, and educators in general that we can hope to broaden the scope of preventive mental hygiene.

THE SIGNIFICANCE OF PSYCHOANALYSIS FOR SOCIAL LIFE*

OTTO RANK
Vienna

IF it were still necessary to prove that psychoanalysis is essentially a normal psychology, although it started in a medical field, was formulated by a doctor, and was developed from pathological material and by therapeutic means, then the proof would be found in the effect it has on the public. It would not have been possible for a medical doctrine or for its application to attract and hold the interest of such a wide public—or, as the doctors say, of the laity—as from the very beginning has been attracted by psychoanalysis. Even the demand for psychoanalytic therapy proceeds to-day, at least in Europe, much more from patients who have heard something of psychoanalysis than from the doctors, who in general combat everything that cannot be grasped from a physical angle. Psychoanalysis is too contradictory of much that they have learned, such as their physiological instruction, their materialistic thinking. Furthermore, psychoanalysis is difficult to learn, because in the first place, it can offer no simple formula of application as can the majority of the special branches of medicine, and in the second place, there are no real schools for psychoanalytic instruction.

So it happened that for the most part only those people became psychoanalysts who themselves had had recourse to psychoanalysis as a therapeutic remedy and by so doing had learned to recognize and appreciate its value. This naturally had its disadvantages. Among these persons were some who were not sufficiently educated to use psychoanalysis therapeutically. On the other hand, the specially trained neurologists and psychiatrists were mostly opposed to a testing of the results of psychoanalysis and so could not be expected

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to understand it and make practical use of it in their own therapeutic field. To-day the situation is that nearly as many non-medical people as medical are using psychoanalysis therapeutically. Freud himself has declared that he has found among non-medical people some of his most intelligent and efficient disciples and pupils. And as the neuroses are more analogous to arrest in development than to disease, in the purely medical sense, the psychoanalyst's task is rather to be compared to that of an educator or a priest than to that of a doctor.

In the beginning only chance comers were analyzed, and these persons were frequently not entirely satisfactory as analysts, because some of them lacked sufficient preparatory education. So a better selection and a more systematic training took place in the advancing development and spread of analysis. The demand for analytic schools that arose in the movement itself was met halfway, so to speak, by an outside factor. This urged that the analytic therapy—which, because of the length of the treatment, was a luxury for only a few wealthy people—should be made practicable for general use. As a direct stimulus to this, the war came and brought to our attention the war neuroses. The war, as a mass experiment—although as such deeply to be regretted—for the first time brought the psychic nature of neurotic disorders before the very eyes of a number of doctors who till then had disbelieved in it. One must admit that the American and English doctors were the first to give recognition to this fact, whilst the continental doctors joined forces with them only later and after some delay. Freud at least was able to use this argument of the war neuroses at the Fifth International Psychoanalytic Congress held in Budapest in September, 1918, shortly before the collapse of the Central Powers. His discussion of these neuroses created such an impression that the military authorities present considered establishing stations for the psychical (naturally not exclusively psychoanalytical) treatment of war neurotics. This good intention unfortunately came too late. For in the meantime it became evident that the whole army and population of the Central Powers had had a nervous breakdown against whose violence every individual psychotherapy would have been powerless.

But the seed began to bear fruit some time later, when the effects of the collapse had somewhat subsided. At the beginning of the year 1921, the first psychoanalytic poliklinik was founded by private initiative in Berlin, and to-day, in the fourth year (1924) of its existence, has already shown good results. Last year the Vienna Psychoanalytic Association founded a psychoanalytic ambulatorium, on the same principle as the Berlin sister institution. With the foundation of these psychoanalytic institutions a new era began for psychoanalysis. Before that it had lived merely an isolated existence in the different *ortsgruppen* of the International Psychoanalytic Association, founded at Salzburg in 1908, which silently carried on the tradition of psychoanalysis and promoted the further expansion of its doctrine and therapy. In contrast to this, the psychoanalytic institutes have two important social tasks which go hand in hand and depend on each other. They must, first, like all similar clinical hospitals, make the advantages of the psychoanalytic therapy accessible to patients without means. The extent to which the population suffered severe psychical injury in the years during and after the war made important in itself an establishment of the institutes. These clinics from time to time have had between sixty and a hundred patients under analytic treatment at the same time. For this a staff of trained assistants and fellow workers was necessary, who must be instructed by the institute itself and whose nucleus was formed from members of the Psychoanalytic Association trained by long years of study and work. So the poliklinik, besides being an ambulatorium for treatment, became at the same time a school for psychoanalytic instruction, which indeed, with few exceptions, is officially excluded from universities. Recently a quite definite schedule and program of work have been arranged for the regulation of theoretical and practical instruction. And to-day these two institutes have at their disposal for teaching and for treatment a well-organized staff which has justified the highest hopes. We trust that soon similar institutions will spring up in other cities and countries, especially in America.

I should like to mention only one point in this connection, not specially interesting to us here, but showing the

peculiar position of psychoanalysis in regard to instruction also, and the difficulties with which one has to contend. In contrast to all other therapeutic methods, psychoanalysis, from its very nature, cannot be demonstrated on the patient himself. This is because the treatment not only requires the full expression of the most intimate thoughts and feelings of the patient, but also rests on the personal relation of the patient to the analyst, which is so sensitive that it would be disturbed immediately by the presence of a third person. There is, then, no other way to learn the psychoanalytic technique than on one's own person, or more correctly from one's own unconscious life. The student of analysis must himself submit to an analysis by a competently trained analyst in order to see how the technique is handled.

This method of instruction has certain advantages. First of all, it serves to free the student from certain inhibitions which would otherwise tend to defeat him in his efforts to use the analytic technique; in other words, it gives him insight into his own unconscious and also shows him the possibility of consciously controlling it. Secondly, he acquires a first-hand knowledge of the groundwork of psychoanalysis, which is necessary for its application to others and which could never be acquired from a purely theoretical study. Thirdly, but not least in importance, it shows in general, from the student's analysis, whether or not he himself is fitted to be an analyst—that is, whether he was attracted to the occupation of analysis only because of his neurotic tendencies, and whether he is in a position through analysis to overcome this motive and to acquire a real faculty for sublimation. At the same time an important practical selection takes place which essentially raises the standard of those to be admitted to the profession of analysts. Instead of the cure of a neurosis, with an exit into psychoanalysis, there now occurs a consciously aimed choice and training of would-be analysts on the basis of their own analyses.

On the other hand, the founding of the polikliniks serves as a stimulus to the attempt to adapt the psychoanalytic technique to mass application. These efforts have not as yet got beyond the trial stage, but I am sure that they will get a final impulse from the theoretical and technical sim-

plifications that have been made possible by the conception of the importance of the birth trauma, and its repetition and overcoming in analytic treatment.[1] For the technical side, one must bear in mind that psychoanalysis was originally a method of investigation whose results psychotherapy will finally be able to use by applying the deepened understanding of the unconscious psychical processes and psychical mechanism to influencing patients in favorable ways. It appears then, according to Freud's own statement, that pure psychoanalysis is on the whole not to be applied as a therapeutic means, but to be combined in appropriate ways with other psychotherapeutic measures. The understanding of the transference mechanism will ever remain the essence of the analytic treatment. This transference mechanism contains in itself all the suggestive factors which the psychotherapist will have to use purposefully and consciously, instead of being led only by his instinct or intuition, which easily may be mistaken. Briefly put, I believe, then, that psychoanalysis will be able, after a long period of investigation, finally to go back again to a kind of Breuer-like hypnosis with katharsis. But only when we are in a position to use all the knowledge gained in the meantime not only to influence the patient suggestively, but also to free him from dependence on the doctor, which Breuer in his time was unable to do.

Whilst we, on the one hand, are devoting our efforts to evolving a shortened and simplified form of psychotherapy, so as to care for the rising generation of psychoanalytic workers, what we call the psychoanalytic movement, on the other hand, is spontaneously working for general progress. It cannot be a matter of indifference in the case of neuroses, whose healing rests on the making conscious of repressed unconscious strivings, in what measure and tempo the general enlightenment as to the causation and genesis of neuroses advances. To be sure we have recognized that knowledge alone does not help these patients. But it is just as certain that an exact knowledge of the cause of diseases, physical as well as psychical, puts us in a position to protect ourselves to a large extent from them. Psychoanalysis,

[1] See *Das Trauma der Geburt und Seine Bedeutung für Psychoanalyse.* By Dr. Otto Rank. Leipzig: Internationaler Psychoanalytischer Verlag, 1924.

because of its general psychological interest, has early succeeded in gaining the notice of a wide public and seems to have passed relatively quickly through the narrow therapeutic phase in favor of the prophylactic phase, which indeed is always the final aim of medical endeavors. It may interest you to learn that we have for many years noticed that the "*grande hysterie*", for example, which Charcot has seen and described so often, is less frequent, at least in private practice. Freud himself incidentally attributes this to the analytic work of enlightenment. But whether this may generally be the case or not, it is certain that we can detect a definite change in the practice of analysis which is largely due to a remarkable decrease of resistances to psychoanalysis itself. In the beginning, naturally enough, only the severest cases of neuroses, which had already gone through various other courses of treatment, came to analysis as a last resource, with the expectation that this also would be of little help to them. But in the last few years we have been receiving for treatment not only lighter cases, but also patients who have a certain amount of confidence in analysis from the beginning. This factor naturally, in such an eminently psychical treatment as analysis, cannot be quite a matter of indifference for the final result. Moreover to-day people seek analysis who really can show no definite symptoms at all, but suffer only from inhibitions, character deformities, and conflicts, from which it is relatively easy to free them before they develop real neuroses.

This change in the public's attitude towards analysis—one indeed to be welcomed from the point of view of social and mental hygiene—can surely be ascribed only to the work of enlightenment, which is just as important here as it is in any other field of social hygiene. Certainly a continuous and intensive work of enlightenment will be necessary, in this as in similar fields, before people will be consciously alive to the nature and severity of neurotic suffering as well as to the eminent social importance of its healing and uprooting. Finally there are here the same resistances at work as in the case of the contagious diseases of the present day, as, for instance, tuberculosis and syphilis, to which Freud has compared the severe forms of psychoneuroses in their

harmful effects on the individual and on society. These factors of resistance are shame, on the one hand, and ignorance on the other. Not only people in close contact with the patients, but even doctors themselves very seldom recognize the beginning of a neurosis, which, besides, from the Middle Ages up to the present day, bears the curse of being misunderstood—only with this difference: the punitive torture that was inflicted upon the neurotic in former times has changed into a medical torture of instruments, electricity, and the like, whilst the social condemnation remains the same. Neurotic patients are themselves ashamed of their suffering, which they vaguely imagine has something to do with their sexual life, and this reaction is intensified by the attitude of those who consider the neurosis as a feigned illness. This explains why, as a rule, the patients themselves, but not their relatives or doctors, have faith in the psychoanalytic treatment; they feel they will not be laughed at or mocked or punished, but will be treated with complete understanding. Till a few years ago, we not only had to fight against the patient's unconscious resistances, which will always remain inevitable, but we also had to face in every single case the resistances of the whole world as represented by the social environment and its ethical standards. To-day, however, this is somewhat changed. I am not referring here to the new type of case, now frequently encountered, in which the patient introduces himself not with a description of his symptoms, but with an analytic statement, as, for example, "I suffer from an Œdipus complex or a strong narcissism, etc."; or, if he is not so far enlightened, at least comes with a certain amount of faith in analysis, shown either in the general remark, "There must be something in it since one hears so much about it", or in the conviction that this method is for him the only possible and right one (a state of mind that one finds mostly in compulsion neurotics). The main thing in such cases is not so much the patient's knowledge as the fact that with it a kind of social authority is granted to the analyst without which no therapy can be effective. It means also that such patients will take the analyst's words seriously, without entering into a discussion of the theoretical foundation of analysis or demanding that the analyst prove each of his assertions.

But the general enlightenment of the public as to the great social importance of the psychoneuroses not only essentially furthers our therapeutic efforts in single cases, but also leads to consciously aimed prophylactic measures. From this we may expect that in the course of time there will be not only a gradual disappearance of present-day clinical forms of neuroses, but also a reorganization of our entire social life and a consequent improvement of our whole social system. The neuroses have proved themselves, as it were, diseases of the family life, the family life being the basis of our social organization. Especially the relation of the child to its parents and its brothers and sisters has proven to be a decisive factor in character formation and in attitude toward life—in the later choice of a profession, in political convictions or activities, and finally in the love life itself. This new insight into family relations and conditions, as well as the new understanding of their importance and bearing, compels us, under the influence of analysis, gradually to change our attitude to the sexual and love life, to marriage, to the family, and to the child.

What psychoanalysis has to say to-day about child education is indeed as yet of a negative or rather prophylactic nature, but is in no way to be underestimated on that account. From the study of neuroses, which represent an arrest in development of the sexual adjustment, we have learned what should be avoided in order to save the child, where possible, from a neurosis. Before everything, then, the child, from the first day of its life—yes, even before its birth—must be considered as a living being capable of taking in impressions and keeping them—but certainly not yet able to work off these impressions. On that account one must save the child from certain experiences that might have a traumatic effect on it. We must begin by enlightening parents as to the sexual hygiene of intercourse and pregnancy. The chief attention in the act of birth must be directed to the suffering of the child, which does not mean, of course, that the care of the mother need be neglected. In the first care of the infant we must begin at once to use the understanding that psychoanalysis has given us of the libidinal processes in the child, which manifest themselves after the birth trauma, espe-

cially in the weaning of the child from the mother's breast and in the first sexual trauma, already recognized in analysis under the names of Œdipus and castration complex. It is not a matter of preventing the child from acquiring the complexes, as one so often hears. The analysis of adults does not even pretend to remove complexes. In both cases it is a question of acquiring the complexes necessary for a purposeful adjustment—that is, for a correct attitude toward life.

The neurotic person does not suffer from the Œdipus complex, as again one so often hears, but from being unable to accomplish it completely; so in the analysis he must subsequently acquire it, as the child must be guided to a proper mastery of it. To save the child from shipwreck in this perhaps most difficult task of adjustment will be the chief aim of child education in the future.

At first these tasks of early infant education will fall to the lot of psychoanalytically trained nurses, since parents themselves will not obtain the necessary knowledge. To do this may perhaps be inconvenient for them, but at bottom this knowledge is easily acquired, indeed already exists, although in unscientific form, among the people. Its influence will reach far deeper, however, when parents themselves adjust their attitude toward each other correctly, as well as toward the child, because more effective than all conscious educational measures is the unconscious influencing of the child through the parents' example, by means of identification and ideal formation based on the libidinal transference to them. Naturally one cannot always expect perfect relations, yet present-day psychoanalytic knowledge already offers us the possibility of putting conscious enlightenment and mastery in the place of a futile, planless groping in the dark. Parents will learn especially not to suppress the child's libido utterances, but to seek to make them harmless by a natural acceptance of them. They will learn not to misunderstand the origin and meaning of the child's faults and not to intensify them by mockery or punishment. They will be able to awaken the child's slumbering gifts and talents and allow them to develop by removing opposing inhibitions and by means of a consciously aimed sublimation. In regard to the

sex enlightenment of the child, one must realize that the best way to bring this about is to avoid any sexual enlightenment at all! I mean by this one must be able to understand and to answer in the right way the direct and indirect questioning of the child, as one would any other questions the child asked; that is, one should not emphasize sexual problems as such, but should carry on sexual explanations gradually, and as obviously and naturally as possible, guided by the child's understanding and curiosity. There should be no definite period or scheme of sexual explanation at all; it should be only a natural part of the child's education and teaching. The first generation of understanding parents and educators had to be analytically enlightened by means of tiresome and long individual analyses, because they themselves needed it. But to-day, by means of literature, general lectures, special courses, and the poliklinik institutions, a wider sphere of influence is possible. This naturally must greatly hasten the process of analytic enlightenment, because it means that whole groups of society can be influenced at once. Centers of enlightenment of this kind are the presuppositions of every lasting influence because psychoanalytically enlightened individuals will have to battle against outside difficulties so long as those around them hold fast to the old prejudices and repressions and consider these individuals as somewhat asocial.

The care and education of children has arrived at a point where the practical application of psychoanalysis must be brought to bear upon it, and there from all appearances psychoanalysis will celebrate its social triumph. The later relations of human beings in life depend so decisively on the relations of the child in its narrow family circle, to the father, mother, brothers, and sisters. So, by the side of the individual love life, which reaches its highest point in the foundation of one's own family, there is also the socially important question of the choice of profession, a subject in which psychology has been showing a practical interest for some time and on which a new light has been thrown by psychoanalysis. Psychoanalysis is now in a position to supplement with material from the unconscious life the work that psycho-technique and vocational education have hitherto been trying to carry

on from the point of view of the conscious life only. Psychoanalysis has made intelligible to us the most important mechanisms for social adjustment—namely, identification and ideal formation in their relation to the parents or their substitutes. This mechanism explains, for example, not only the wide group that chooses the same profession as the father, but also some characteristic deviations, which may lead even to opposite extremes. A second important factor in the choice of vocation is sublimation, which is able to refine certain primitive impulses arising from erogenous zones or infantile objects and so make them not only compatible with the ego, but at the same time socially valuable. Understanding of the unconscious determinism of the apparently free choice of vocation may be called the social counterpart of the analytic concept of the rigorous determinism of the love choice in the Œdipus complex. And so analytic enlightenment enables us to mitigate mistakes in vocational choice also. These mistakes, or rather the results of them, we can best recognize in the human wrecks of all kinds, from the asocial up to the definitely pronounced criminal types. In this field also prophylaxis will have an enormous influence, in which child-welfare and social workers will coöperate with psychoanalytically trained doctors and educators. Antisocial human beings cannot always be cured by psychoanalysis alone, but they can be thoroughly understood by means of it. Psychological understanding of the criminal type began with the analytic study of certain patients whose antisocial or criminal inclinations led them to be analyzed before these impulses had become socially harmful. For instance, the study of kleptomaniacs has thrown an important light on the origin of the impulse to steal. Also, the analytic understanding of certain cravings for alcohol or drugs has contributed to the recognition of an essentially distinguishing trait of criminals. When we speak of a confirmed drunkard or a confirmed criminal, we emphasize instinctively the fact that the antisocial conduct is a matter of an irresistible compulsion, a compulsion which we can compare only to the neurotic compulsions; and we know that these can be removed by analysis. We can get some idea of the strength of these compulsions when we remember that the typical confirmed criminal is deterred

by no kind of punishment from the repetition of his deeds; the reason for this lies in the biologically rooted mechanism of the compulsion repetition which he uses in a wrong way and which can be socially directed. We are already sufficiently advanced to understand the psychology of a certain group of pronounced criminals, but at present the social means for applying the knowledge profitably are lacking. To-day we can at least diminish prophylactically the percentage of such persons, by providing favorable surroundings and possibilities for sublimation. On the other hand, one must not forget the type of criminal described by Freud, who commits his crime from an unconscious guilt feeling which desires to be punished. So the criminal often wants to be locked up because he gains unconsciously masochistic pleasure from it, as we know many children get pleasure from being beaten. The criminal's conscious motive, or rather rationalization, frequently is to gain a care-free existence from the state, symbolizing the mother. The real unconscious aim manifested in conduct that leads to being isolated and locked up in a cell points even more directly to the return to the womb. So, paradoxically, the criminal gains unconscious pleasure, while the authorities think that they are punishing him, and so he gets by delinquency the same gain as the neurotic who shuts himself away from social contact by his symptoms.

I hope you will not get the impression from my arguments, which have only tried to throw light on some social problems, that I expect from psychoanalysis a kind of ideal state after the manner of Plato's, which was more of a Utopia. But I really do not think that I have taken too broad a view or that I have proposed anything unattainable. On the contrary, I have attempted to start with what can be conceived as already on the way. I only wanted to show you how and where it is possible for each one of us to contribute something toward alleviating as far as possible the misery of individuals and so finally of society itself.

INSANITY AND CRIME*

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SINCE the famous McNaghten case in England in 1843 the concepts insanity and crime, which up to that time had remained fairly distinct, have become progressively more and more closely associated until now they are so entangled that it is sometimes difficult to separate them. Nevertheless, the problems presented by both insanity and crime are of such outstanding importance that clear thinking about them is very necessary, since clear thinking is the first essential for intelligent action. It is to this problem of insanity and crime, obscured by long association, that I invite your attention.

Since Professor Einstein's very important announcements, which have caught the imagination of the world and profoundly influenced its thinking, we have come to realize that we no longer live in a three-dimensional universe, but that our universe is four-dimensional, the fourth dimension being the dimension of time. To give a simple illustration, if I want to become acquainted with John Smith and know anything about him from personal contact with him, I naturally will have to seek him out, and it will not be enough for me to locate him in *space,* the place where he lives and can usually be found; if I wish to know him, I must call upon him at a *time* when he is there. It is the same with anything else about which I desire to know—I cannot know about it really without considering the dimension of time. We would, for example, know nothing about the appendix veriformis if we had not studied the history of its development in time. We could not possibly understand the meanings of customs, the traditions of the race, the ceremonials of institutions, or the study of life in all its numerous manifestations except through the study of the history of their several developments, their evo-

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lution. To study the meaning of crime and of insanity, we must pursue the same method, for unless we do know something of the historical development of these two concepts—unless we know the direction in which that development has been proceeding during the past—we cannot have any feeling of certainty as to what that direction may be in the future. By acquainting ourselves with the history of an existing situation, we are thereby acquainting ourselves with its factors and possibilities for the future.

The history of crime is really lost in the past. We do not know where the idea of crime began, except that we have assurance that certain things, in very early days, with primitive people—certain acts that differed from those generally accepted—were prohibited and were, therefore, taboo. If an individual member of a savage tribe offended in regard to something the entire group believed in, he was committing what we would call an antisocial act, and in many instances the offense was punished immediately. There was no such thing as a trial, and punishment was almost always death. Another group of offenses, which perhaps are of a little more interest from our point of view, were the offenses against persons, against the individual—acts that are now called torts instead of crimes. It is very interesting that in the development of the idea of crime many of these offenses against individuals have been transferred from the group of torts to the group of what we know as crimes.

It early became apparent—probably not consciously apparent, but apparent from the actions of the group—that the individual who had suffered some wrong from another individual could not be trusted to effect his own redress. So, very early in the history of antisocial conduct, the redress of personal wrongs was transferred to a special group which could be expected to carry out this matter of redress very much more intelligently than the person concerned, and very much more wisely for the welfare of the group as a whole.

Offenders in early times were taken into custody and kept in prisons rife with all sorts of disease, with all manner of infection and contagion, and persons accused of all sorts of crimes were kept together. In England any one who stole anything that was valued at two shillings or more was hung,

and he wasn't hung in the jail yard—he was hung on the street corner in the public square where every one could see the performance. And the people crowded the public square to witness the event. The whole affair was made a picnic. The hanging was made public because this manner of punishment was supposed to have a salutary effect upon the people, who would take warning from what they saw. However, nothing of the kind happened; it was made a gala affair instead. What happened during this atrocious state of affairs? It soon became apparent to the people that this was essentially vicious, and the trial juries corrected it very wisely, because the jurors were the judges of the facts in the case and they began very frequently to bring in a verdict that the value of the article stolen was less than two shillings, no matter what the article was. In other words, there was a beginning of a change of practice which was inaugurated by, I may say, an instinctive tendency in the human breast to exercise a certain element of sympathy for the unfortunate.

That tendency, which started in this simple way, has been going on, the number of crimes on the statute books that are technically punishable by death growing less and less, until to-day the crime of homicide is practically the only one left; and because of the waning tendency of jurors to find the culprit guilty and of judges to sentence him to death, this crime is less and less frequently so punished.

It is important to bear this history in mind. When people talk of crime waves, we often hear increasingly severe punishments suggested as a remedy. But if one remembers the history of the treatment of crime, it is evident that this suggestion would result merely in regression; we would be going back to what, because of our greater knowledge and developed humanitarianism, we have left behind. Evolution has been defined as a process that is irreversible. We can't go back; we may try, we may make a partial success, but it can't last long.

Another thing came along very shortly. The individuals who were punished began to be appreciated—some of them—for what they were. It began to be seen that certain crimes were committed by people obviously mad. A hundred and fifty years ago, "obviously mad" meant something. It meant that

the individual was raving, wild, and a man of that type was early recognized as an individual who ought not to be executed or seriously punished for any offense. When that realization came about, there entered upon the stage for the first time psychiatry and the recognition of the relation of mental disease to crime. And for the first time law began to take cognizance of the human material it had to deal with. Almost exclusively then, and largely now, the law has dealt with the *act* rather than with the *actor*. It has never been the method of the law to inquire into the spiritual, moral, or mental make-up of the individual. The "mad" man was recognized as a sort of irresponsible person first, and this gradually brought about the recognition of the make-up of the individual in relation to the crime committed, and affected the decision as to the way in which he should be disposed of or punished.

From that date to this there has been a long, complicated, and difficult history to understand; there has been more and more of an entry upon the stage of psychiatry, more and more interest in mental disease as a means of evaluating the individuals who committed these antisocial acts. The law in the main has not followed this development; the law in its formulation has stayed very much where it was a hundred or more years ago.

Now this history has been largely a history of the various tests that have been suggested and applied from time to time to determine the presence of insanity. There was an effort made on the part of the law to define what it called the "guilty mind", which meant, roughly translated, the harboring of a vicious impulse by a mind that was normally constituted or sane. We might think to-day that this was a contradiction in terms, but the law was trying to define a guilty mind and what constituted a disordered mind from its point of view. Now in undertaking to reach a practical decision as to what constitutes a disordered mind, we want to remember three individual concepts with which the law is constantly dealing and which are not only interesting, but very important. We have, to begin with, the concept of *responsibility*. The law undertook to say that the person who harbored a vicious or evil impulse and permitted himself to execute that impulse was responsible, but the person who according to the law

was "mad"—was "beside himself"—was not responsible. Roughly speaking, that meant that the individual who, because of mental disease, was not responsible was, by that same token, not guilty. When a defendant introduces a defense of insanity, he undertakes to prove his irresponsibility, because if he proves himself irresponsible, he proves his innocence. The result has been that we have the whole sordid picture of the court as a battle ground for determining a scientific issue.

Another concept is the concept of *guilt,* which assumes that the individual who committed the antisocial act, unless insane, is guilty, and the third concept is that if he is guilty, he is therefore *responsible* and ought to be punished, and it is the function of the criminal court to mete out that *punishment* which is supposed to be appropriate for the offense.

All these concepts of *responsibility, guilt,* and *punishment* are very ancient. They were formulated and laid down and crystallized in the language that we speak, in the form of words, many, many years ago, and by necessity they bring along with them out of that past much of the flavor that was associated with their meaning in those hygone days. So, when we speak now of crime and innocence and responsibility and punishment and use those terms without thinking of their possible significance in this twentieth century, we are of necessity carrying along the burden of medievalism with which those terms are laden.

It is upon the basis of these concepts that we are trying to formulate a series of punishments that presumably are to have a rehabilitating effect upon the public and the criminal. In primitive days, when a man stole, they cut off his hand; when he lied, they cut out his tongue. That was logical. When a man nowadays steals fifty dollars, "How long should he be imprisoned?" is the question that confronts us. How can we tell what would be the logical limit, any more than the doctor who is asked how long his patient will be ill and whether he will live or die? The patient may be ill for a week or he may be disabled for months. There is equally no possibility of fixing in advance punishment suitable to a crime. So we are confronted with this situation—this strange mixture of medievalism and conservatism versus scientific

thinking which talk different languages, which are not understood one by the other, both of which are pounding away at the same problem, both seeking some kind of solution.

Now, from the standpoint of the psychiatrist, the solution, in its broad outlines, is not difficult to lay down. I am concerned with the type of solution that gets us on the right road, with a fairly clear idea of where we are heading. Then again, I have an abiding faith that ultimately we will get the knowledge we are seeking, and between now and ultimately we are at least on the right path to improving conditions.

The history of the development of these ideas, *responsibility, guilt,* and *punishment*—of the ideas of criminal law and the guilty mind—shows fairly clearly that at the bottom of the whole business there is man's desire for *vengeance.* When an individual is injured—when the group to which he belongs is injured—he wants to get even with the fellow who injured him, and perhaps one of the most significant things in the history of the development of the idea of crime is that it goes to prove that this is the correct idea of what lies back of these concepts. It is a very recent development in our practice of criminal law that connects the antisocial act with the individual who committed it. Ordinarily, at the present time, when something has been stolen or when somebody has killed some one else, the first thing we try to do is to find out who the guilty person is before undertaking punishment. That isn't the way our forbears went about the matter. If some one in one group was killed, some one else had to be killed in return, and it didn't make any difference who did the original killing. The group had created in its breast this desire for vengeance, which was put there because of a wrong that they had suffered, and they could get a sufficient expression for that desire for vengeance by killing anybody. At one stage of development they hung the fellow they got hold of first and tried him afterwards. Then they began to try to hang the fellow who did the wrong, and that is a very late idea in the whole scheme of things. So what really happened was that the people who had this feeling of vengeance found a way to satisfy it that was socially permissible. If you will go to-day to the hill countries where

the feuds exist, you will find that if there is a feud between the Smith and the Jones family, and a member of the Jones family kills a member of the Smith family, one of the Smith family must kill a member of the Jones family in return. It need not necessarily be the one who did the original killing; it is just a matter of killing a member of the offending group. Fundamentally, there is the idea of vengeance—the idea of revenge—and that is the way in which our ancestors, far back, used to try to get satisfaction.

Now coming back to the suggestion that I spoke of first—that what we ought to do is to punish more severely—I should like to question the meaning of such a suggestion. We have come a long way from the primitive expression of vengeance; we have gone forward on a humanitarian pathway to what, we believe, is better; and to go back to more harsh measures would only be an attempt to go backwards along the pathway of life, which cannot be done. However, it is a prescription that, if it were taken, would result in the unleashing of peoples' tendency toward revenge, which the whole progress of civilization has been trying so hard to keep in leash. All cultural development has been addressed to building fences around these instincts and keeping them confined, and when any one suggests that we go back to that early state of affairs, he is just advocating a prescription for tearing down the fences civilization has been building up. Fortunately this cannot be done.

The reason I direct attention to this trend is because if we waste time in talking about such impossible solutions, our eyes will be directed away from the possible solutions. Our energies ought to be turned into more useful channels.

How are we going to approach the problem? Historically, I have shown you how it had its origin in vengeance—how the very machinery is filled with archaic elements that bring into the present the flavor of the remote past. How necessary, therefore, it is to examine the tools with which we are now attempting to solve these problems, and how obvious it becomes that we are trying to solve twentieth-century problems with seventeenth- and eighteenth-century machinery. It can't be done. It is a fundamentally outstanding change that has taken place in the twentieth century that makes me say

that all this machinery is antiquated and no longer competent to serve twentieth-century needs, and this thing has happened within the last twenty-five years. You will find that the idea of relativity is seeping through every type of thinking. Nobody is any longer willing to accept as an absolute finality any decision from anybody. We have appreciated for the first time, more widely, more consciously than ever before, that we are living in a universe that never solves any problem permanently and everlastingly—a universe that is in a state of eternal, everlasting, continuous change and movement. Nothing said yesterday holds true to-day, and we do not expect that anything said to-day will hold true to-morrow. We have got to fit our solutions to the times.

During this time things have happened more definitely in the field of psychiatry than perhaps in any other field of medicine. Just as in the old days the criminal was considered an individual who had done something wrong, so in illness the matter was considered a purely private, individual affair. Take, for instance, smallpox. After some one has discovered that it is contagious, then when Mr. Smith and Mr. Jones have smallpox, it dawns upon people that it is no longer a private affair. The same thing has happened in psychiatry as in general medicine. Insanity and crime are matters that have enormous community and social interest. Crime has always been considered as largely an individual affair, from the point of view of guilt and punishment, and is still so considered to some degree. The question was, Is he guilty and responsible, and, if so, what is the punishment? We are no longer interested in guilt because our interest is no longer with the individual and we are not interested in punishment because we, psychiatrists, have evolved to the next stage of culture that transcends the individual—that is, the social stage. There is nothing more significant of psychiatry in the twentieth century than its social aspect; significant not to the individual, but to the social group and the responsibility of the social group for the individual.

We are interested in human behavior; we are interested in behavior that is disruptive of the social organism; we are interested in knowing what is going to be done about that behavior. We are interested in curing that behavior, and

making it an asset, if it can be made an asset to society, and if it can not, in protecting the group against its destructiveness. From that point of view, the problem is really very simple. Here we have an individual who is active in an antisocial manner. Now why indulge in arguments as to his guilt or responsibility? We should not be interested in criticizing. Our purpose should be a social purpose. Whether some one is going to act in an antisocial way, that is what we want to know—that is the problem the criminal puts before us.

There are two considerations to be kept in mind in solving this problem. In the first place, there is the protection of the group against the antisocial individual. The next thing to having that individual shut up is to study him and find out what sort of person he is. The complete understanding of the individual from the ground up, not only physically, physiologically, mentally, but his whole past history—individual, social, hereditary, the entire past—is essential. What is the use of all this? We want to solve this problem of crime; we want to study completely the individual involved. Our hope is to find out what sort of people are committing crimes and having found out what sort of people they are, to deal with them for what they are. Suppose, for instance, you have a patient with typhoid fever and a patient with a broken leg—would you give them both the same medicine? We want to find out what sort of people these antisocial individuals are and to deal with them accordingly. A certain portion of them will be hopeless so far as making them social assets goes. If they are going to be social liabilities, shall we let them out in six months or keep them locked up? We must learn to gather our material and prescribe accordingly. That sounds simple, but it has taken years and years to come to even such a simple solution, and I take it that the principal reason why we have not come to it before is that we have been tied to medieval methods of thinking by such words as "guilt" and "punishment".

The power of words that control our ways of thinking is stupendous. Millions of people were mobilized during the recent war by the meaning that was crowded into the single word "patriotism". So we have carried the burden of centuries on our backs because of words. One beneficent thing

that has happened as a result of the war is that we are now in a state of mind where we are psychologically oriented towards throwing aside tradition. While doing so, let us throw aside the bad ones—all of the bad traditions of violence and revenge and hate, which are included in the make-up of such words as "guilt" and "punishment"—and, taking a broader view of the social aspects of criminology, let us learn to gather antisocial material and deal with it for what it is.

Not long ago I was talking with a doctor who has had a great deal of experience in dealing with the problems of children, and I said to her, "I should like to get your reaction on this question. Do you think, with your knowledge of children, that it would be possible to sift out from the youngsters that you have to deal with under twenty years of age those who are potential criminals? You know, and I know, perfectly well that no man ever goes to the electric chair, or ever goes to prison for life, who hasn't been writing in letters four feet high, if we had but the sense to read them, that there was where he was heading. What is your reaction to picking out those youngsters before they have cut somebody's throat?" She answered that we could get lots of them and save them from becoming liabilities by handling them properly in early life. I know that we can get lots of them. Just think, isn't it stimulating to be able to get these fellows before they get to the electric chair and make them assets in society? The majority who have led a crininal life have begun crime as children. At the age of thirty the offender may become a murderer, for it is at that age that his crime is brought to light, that his criminal tendencies have become full grown. If he does not get to the electric chair until he is forty or fifty, that is because he wasn't caught earlier.

Now briefly, in closing, let me sum up the suggestions that grow out of what I have just said and that indicate the principles upon which psychiatry and criminology can function jointly and to mutual advantage.

In the first place, I believe that questions of guilt—using that term in its moral and theological implications—and personal responsibility should be laid aside in favor of the social concept of the social usefulness and assimilability of the

individual; that those individuals who are socially dangerous should be segregated, irrespective of what particular crime may have brought them to public notice; and that their segregation should continue not for a definite, prescribed period of time, but for so long as they continue to be a social menace. I would call your attention, in this connection, to recent legislation—I have in mind the state of Illinois—which provides for the commitment of feebleminded persons with dangerous antisocial tendencies in appropriate institutions.

This program would involve the definite segregation of the so-called criminal and would be difficult to provide for unless it could be carried out on lines that would inspire public confidence. I have in mind, first, that our prisons need to evolve in the main in two directions. First, they should as far as possible eliminate all methods that have as their immediate objective the frustration of the prisoner and should substitute methods that give him as nearly as possible the means for reasonably adequate creative self-expression. This is development along the line of humanitarianism and rehabilitation. Second, the prisons need to become establishments animated by scientific curative and research ideals. They should aim ultimately to become laboratories for the study of human behavior and the means of its conditioning. If these reforms could be carried out, there would be no greater resistance on the part of the public to giving its acquiescence than there is now to the commitment of the insane to hospitals for the care and treatment of mental disease; and the net result would be that a very large proportion of unassimilable, irreclaimable, antisocial material would be permanently segregated in an environment that would not be repulsive, but, on the contrary, would offer opportunities for maximum individual development and its useful expression. There is nothing theoretically in the way of making our prisons huge workshops that would be economic assets to the several states.

Our existing legal machinery is quite incapable of dealing adequately with the question of crime because of the reasons I have given. The changes that need to be effected in this machinery would come about, according to my way of thinking, by following lines similar to those that have been developed in medicine—namely, the lines of education and

specialization. I believe that more attention should be paid in the colleges of law to the study of criminology in all its various ramifications, including its social and its scientific aspects; that students should be encouraged to specialize in this branch of the law; and that adequate postgraduate courses should be developed to this end. If this were done, it would naturally follow that judges would also come to be specialists in the application of the criminal law, and our criminal courts, instead of being battle grounds between the accused and the state, would become centers for the application of scientific treatment to social problems. This would involve also the taking of certain positions out of the realm of politics and filling them upon the basis of demonstrated ability grounded upon proper preparation. I have in mind more particularly the district attorney's office. The district attorney and his assistants should be trained criminologists with an understanding of the scientific principles involved in this department of science and with an understanding of the nature of the human material with which they have to deal and the possibilities that it presents for treatment in various ways.

I do not believe that there is any royal and easy road to the accomplishment of highly important social ends. In order to deal with crime as it exists in this twentieth century, the machinery that has grown up in the past must be modified upon the basis of careful analytical study and the bringing together of the best thought in all related fields. Psychiatry and criminology, in my opinion, make up the most valuable combination that can be suggested for effecting these ends.

SOME TRENDS IN THE DEVELOPMENT OF RELATIONSHIPS BETWEEN PSYCHIATRY AND GENERAL SOCIAL CASE-WORK*

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FOR over two years it has been necessary for me to come into close contact with "general social case-work", in the process of developing those coöperative relationships with the organized social work of the community which are essential to the success of the program of the child-guidance clinic. In doing so, it has been necessary to understand, as well as an outsider may, what the social case-worker is doing and why, and what, if anything, psychiatry has to offer to her in her daily work. From this necessary study of the principles and practice of general case-work, and from experience in dealing with social case-workers on definite problems, have come certain conclusions which seem worth general discussion.

It is not easy to obtain a clear understanding of what is usually meant by social case-work, to grasp the interrelationships of the processes employed in case-work technique, and to see the whole field in its complicated professional relationships. Nevertheless, these points must be understood before an evaluation of the common factors in the fields of general social case-work and psychiatry can be made.

AIMS OF SOCIAL CASE-WORK

In her book, *What Is Social Case-Work?* Miss Richmond gives the following definition: "Social case-work consists of those processes which develop personality through adjustments consciously effected, individual by individual, between men and their social environment." This definition is a standard one, and comprehends all others encountered. The

* Presented in outline form before the Section on Psychiatric Social Work of the American Association of Hospital Social Workers, Denver, June, 1925.

first point stressed is personality development, which I take to mean the development of individual capacities and the building of individual character (or resistance), with the aim of fitting the person to withstand the stresses and strains of competitive social life. This must be done by individual adjustments consciously effected between the person and his social environment, which means that the problem must be approached not only from the standpoint of the individual, but also from that of the environment and its resources, with a view to utilizing every measure available for bringing about those adjustments which develop personality. As limiting factors in developing individual personality alone, the social worker could consider the needs of the family or of the social group to which the individual belongs or must conform.

A very important question here has to do with the origin of the need for developing personality or effecting adjustments between individual and environment. Cursory survey indicates that *lack of adjustment within the individual* is perhaps the greatest single factor. We may express this lack of intra-personal adjustment in psychiatric terms, recognizing that mental diseases and defects, neuroses, psychopathic states and conflicts, and the like, are all evidences of lack of intra-personal adjustment and that they hinder the development of personality and produce difficulties in adjustment between individual and environment. For example, the annual report of The Associated Charities of Cleveland for 1924 divides 22,522 problems in 7,996 families into five groups as follows: physical and mental disability, 33 per cent (26.5 per cent physical, 6.5 per cent mental); personality maladjustment, 32.5 per cent; economic problems, 18 per cent; educational problems, 9 per cent; environmental problems, 7.5 per cent. Assuming that all instances of personality disorder (conflict, psychopathy, neurosis, defect, psychosis) are actually included in the proper group here and that none are improperly included, we have 39 per cent of intra-personal maladjustment in this one year's work. In Miss Richmond's Book, *Social Diagnosis,* it appears that over half the cases present problems in personal mental adjustment of all degrees of severity.

In all these cases of intra-personal maladjustment, this maladjustment must constitute a very definite limiting factor in the development of personality or in the effecting of adjustments between individual and environment, and it would apparently be the first problem that must be met in one way or another. One of the first needs is to separate the problems into those that can be met and those that cannot; another is to determine in which cases the direct (psychotherapeutic) attack is most effective, which should be approached by indirect methods (social-manipulative), and which are best attacked by a combination of both methods. In case-work technique, the social worker seems to me to have included both types of approach without, in general, recognizing that many features of the treatment are of the same type as the measures that the psychiatrist employs. Many social workers are exceptionally skilful in dealing with people. They seem to belong to the group which Dr. Williams has said "have an exquisite sensitiveness to living", and through *their feeling* for people and motives, they add greatly to their work and to the technique of their profession.

AIMS OF PSYCHIATRY

In his *Foundations of Psychiatry,* White views present-day psychiatry as "a method of approach which . . . sees in the mind, the personality make-up, the final expression of the total integration of the individual into an organic unity . . ." Elsewhere he speaks of it as "dealing essentially . . . with total reactions—that is, reactions of the individual as a whole, which is only another way of saying mental states . . ." Hence psychiatry is concerned with the development of personality.

The psychiatry of to-day is concerned essentially with the adjustment of the individual to himself and to his environment, so that full functioning of the entire individual may result. Interested primarily in the individual and in individual reactions, it nevertheless must take into account the complicated interplay of reactions between individual and environment, and finds it impossible to consider the living, reacting organism apart from the situations that produce or modify or are affected by the reactions of the individual.

Thus psychiatry is concerned with all the adjustments and maladjustments of the individual and their social effects. Persons come into the purview of the psychiatrist because of some disturbance in behavior (total reactions) which leads to a suspicion of mental maladjustment. The types of behavior disturbance and maladjustment vary greatly, from minor to major. The simplest types are those in which an emotional conflict or complex is producing difficulties in some field of reaction, even though most of the individual's behavior may be satisfactory and successful (the essentially normal). There are next the psychopathic and neurotic states, with their more elaborate mechanisms and more marked disturbances of behavior, usually requiring a more vigorous type of psychotherapy. Finally there are the defect and disease states, as they are usually termed, with their very marked mechanisms, organic or functional or both, which in general require a special (institutional) environment over rather long periods, with special forms of education (in the case of defectives) or a wide armamentarium of treatment measures (medicine, surgery, psychotherapy, *et al.*), the latter being especially the province of the physician. But in all the groups there is the same need for patient study of causes and for treatment of them by any methods that are available, whether these be direct or indirect.

The development of psychiatry to this point has been a relatively slow matter, but the great advances have come in the last fifteen years. It is during this period that all but two of the "psychopathic hospitals" have come into existence; that The National Committee for Mental Hygiene has been at work in its many fields; that hospitals for mental diseases have employed social workers; that special training for psychiatric social work has been established; that hospitals for mental diseases have established out-patient departments or clinics; that community mental-hygiene clinics of various sorts have been established; that psychology and psychiatry have joined techniques on many problems. Perhaps the greatest change has been in the formal point of view of psychiatry, developing as it has from a descriptive analysis of symptoms presented in disease states (the so-called "static" psychiatry) to an interpretive, mechanistic study of person-

ality maladjustment (the "dynamic" psychiatry) with an increasing emphasis on psychotherapy in its various forms, while not neglecting the need for sound organic therapy as a factor in producing stabilization of the personality and promoting its efficiency.

Apparently the greater number of psychiatrists will always be primarily concerned with the grosser deviations in personality adjustment, which demand institutional care, or the more difficult procedures in psychotherapy. But there can be no doubt of the trend toward carrying psychiatry more and more into the non-institutional field and so into contact with the less marked deviations, where treatment involves consideration of the capacity of the individual to withstand stresses and strains as related to the stresses and strains encountered. This should result in the prevention of grosser deviations by proper treatment of minor ones, and thus it represents, in the broad view, the general aim of mental hygiene.

RELATIONSHIPS BETWEEN THE TWO FIELDS.

The foregoing sketch of the aims in the two fields has attempted to show that there are problems and techniques common to both and problems and techniques peculiar to each. My contention is that when the social worker passes beyond "relief work" to "case-work", as it is ordinarily defined, she enters a field in which the mental-hygiene factor bulks large and in which she has need of the data and techniques of psychiatry. On the other hand, when the psychiatrist leaves the field of the gross personality deviations, he enters one in which he has need of the data and techniques of social case-work, so much so that the "psychiatric social worker" has been evolved. Any study of treatment plans shows that the social worker uses methods of influencing the client which might be called "psychiatric", especially when she varies her methods to meet the "peculiarities" of the individual; while the psychiatrist uses many measures ordinarily thought of as "social", such as changes of environment, recreation, and the like. It is *not* contended that either is necessarily the leader, but rather that, for certain types of problems, they constitute a unit working together for the

benefit of the client, each not only supplying special techniques, but contributing to a pooled or common technique as well. There is perhaps a further contention that the social worker would benefit in her work with many cases if she had more understanding of the mental-hygiene factors involved in such problems. If these contentions are adequately supported, the question becomes one of determining by what methods the relationship may be further developed to maximum advantage.

SUGGESTIONS FOR A PRACTICAL PROGRAM

Apparently the primary issue is the education of social workers. As a rule the social worker is exposed, during her training, to a course of from ten to twenty lectures on psychiatry and perhaps an equal number of lectures on psychology. These lectures are usually given, it would appear, by a busy professional person, well grounded in the subject, but all too frequently uncertain as to how far his material is adapted to the training or the needs of the group he is addressing. It is my increasing conviction that such series of lectures cost more in time and effort than they are worth in practical effect. Two factors enter into this—the small amount of time given up to them and the way in which the material is presented.

The latter factor seems to me the more important, though not much is to be expected until more time is given to psychology and psychiatry as related courses supplementing each other. Apparently most courses in psychiatry have been concerned with describing the symptoms, causes, and treatment of the *psychoses,* and the major portion of the time is devoted to this. It is clear that the social case-worker needs to learn the major indicator signs of gross mental disorder, in order that she may get her client into proper hands for treatment. But there is, as a rule, little that she can do in such treatment, and the concepts so gained are of value chiefly if she can, through them, acquire insight into less marked problems in mental adaptation, of which the grosser deviations are in some way exaggerations. For the most part, this type of teaching seems to give the social worker a few new terms for acrobatic vocabulation, and here and there certain pre-

viously puzzling problems in her experience are illuminated. But the final test of all such teaching is its applicability to concrete situations, and this seems to me, with increasing experience, increasingly doubtful. Further, the learning of a set of diagnostic terms is of doubtful value because of its effect in giving the social worker a sense of finality, so that the diagnostic term itself tends to prevent a real effort to penetrate to the background of the abnormal state expressed by it. Yet effective treatment can come only from an analysis of the mechanisms which, by their interplay, have produced the state for which the diagnosis is a label.

As a result of experience with several courses of such lectures, it seems to me that an entirely different approach is needed. While details of this are not yet clear, the last course given may be taken as a basis from which to work. In it, one-fifth of the time was devoted to the habits, complexes, and conflicts which, in normal people, interfere with their success; one-fifth to the psychopathic states; one-fifth to the neuroses; one-fifth to feeblemindedness and epilepsy; and one-fifth to the psychoses. The approach to the whole field should be from the genetic standpoint; and, with sufficient time available, the formulation of mechanisms into specific psychopathological trends or deviations should be preceded by a detailed discussion of the normal integration of the personality, which would indicate the specific points of origin, both in time and function, of skew mechanisms. If the student is well grounded in this by the discussion method, with the use of ample illustrative material—particularly a careful searching out of mechanisms in the student herself—then she should have a real and effective understanding of the mental mechanisms of her clients and of ways of dealing with them. Under such conditions the amount of time spent on the formal groupings of psychiatric material may be greatly reduced without in any way impairing the worker's necessary grasp of such material.

It would seem desirable to have at least sixty hours of group work for such a course or courses. In addition, there should be from five to ten hours for the presentation by each worker of case material which she has analyzed from the point of view of the personality factors involved in the

production of the problem and the methods chosen to meet them.

I do not claim that such a cause as this would produce trained psychiatric case-workers; that is another problem. But I do believe that it would produce, on the average, general case-workers who are more effective. There are many problems for which neither psychiatry nor case-work has the answer, and no revolution or miracle is expected from any such scheme. But if the major factor in social case-work problems is the individual client, then social case-work needs all the understanding of personality and personality deviations that it can get from any source, and it is important that psychiatry be prepared to do its share in meeting this need.

THE CHILD FACTOR IN THE TEACHER-PUPIL RELATIONSHIP*

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THE AVERAGE pupil does not constitute a problem to the average teacher, but the atypical pupil brings with him many difficulties even for the specially trained teacher. School procedure aims primarily at the needs of the average pupil and meets his needs satisfactorily. The practice of pedagogy, however, has been enriched by its efforts to meet the recognized needs of the feebleminded child and the child of superior intelligence; so we are justified in the belief that further enrichment will come from the study of other types of atypical children. After all, the average child shows all the tendencies that are manifested in an exaggerated form in the atypical child. It is a question of quantitative rather than of qualitative differences.[1]

To understand the pupil when he comes to the teacher, it is necessary to know something of the child and of his experiences before he became a pupil. The child has developed definite methods of meeting situations before he begins school. His pre-school life has been largely taken up with the molding of his instinctive and emotional mechanisms. These have been modified by his daily contacts in the family. He has tried these mechanisms on his parents and on his brothers and sisters. As a result of these experiments, he has discarded many that have proven ineffective, and has become more adept in the use of those that he has found effective. Immediate satisfaction for himself, rather than social desirability, has been the determining factor in this sorting process.

The child goes to school because he is sent. As a rule he embarks upon this novel adventure with eagerness, but the

* Read before the Southwestern Educational Research and Guidance Association, Los Angeles, December, 1925.

[1] *The Normal Mind*, by William H. Burnham. New York: D. Appleton and Company, 1924.

fact remains that he is sent. It is the first laboratory in which he makes trial of the reaction tendencies developed in the home. He comes to school with well-defined attitudes toward other children, toward play, toward himself, and toward authority. He has loves, hates, and fears. He has thoughts and an individual personality. Yet none of these are permanently fixed, but can still be molded by a deft hand. It is for these reasons that the teacher should have a broad understanding of the psychological make-up and mental mechanisms of the child.

One of the outstanding facts in the teacher-pupil relationship is that the teacher is a symbol of authority to the child. She is the all-knowing giver of knowledge, the assigner of tasks, the disciplinarian, and the sole arbiter of all disputes. In the school the authority of the parents has been transferred to the teacher, with all the feelings and attitudes which the child has learned to assume toward authority. This phenomenon is the source of many of the teacher's opportunities and many of her difficulties. Each child develops his methods of reacting to authority from his previous experiences.

Originally the child is helpless and dependent upon parental care and attention, but, with the growing consciousness of self, there develops an increasing desire to gain satisfaction by attaining his own ends. There develops not only a desire for satisfaction, but also for self-expression, for childish domination.[1] These impulses are among the strongest driving forces of the child's personality. They come into early conflict with the dictates of authority, whether in the person of the parent or of the teacher. They are explosive and may explode if too tightly compressed by the teacher's need for the maintenance of order. They may exhaust their strength in useless effort against this too unyielding bulwark. They may become a most useful instrument in the hands of an understanding teacher by providing the driving power for worth-while accomplishments. There are as many different reactions to authority as there are different children and different circumstances, from complete submission at one extreme to open rebellion at the other.

[1] *The Neurotic Constitution*, by Alfred Adler. Translated by Bernard Glueck and John E. Lind. New York: Moffat, Yard, and Company, 1917.

Some children fail to develop emotionally beyond the stage of infantile dependency upon the parent. When school age is reached, children of this type will depend upon the teacher for their every decision. In every act they will look for the teacher's attention and approval. Their primary desire is not to please the teacher, but to gain the attention that they crave. Their submission to authority is complete, almost groveling. They will make no effort without the most explicit directions. The teacher must carry the whole responsibility. They may try to attract the teacher by their ready compliance, solicitous manner, and over-friendly smile. If these methods fail, they may secure the teacher's interest by mysterious pains and aches, or by rambling talk about themselves, their families, or their pets. On the surface, they appear sympathetic and unselfish. At heart they are not generous, but are always trying to get more than their share by means of their sweet, submissive domination. Appearing hurt is their chief stock in trade.

Charles was such a boy. When asked how he liked school, he said, "Oh, I just love it! All the teachers are good to me." And, anxious to hold our attention, he went on, "Some of the teachers weren't interested in me last year. The teacher thought I bothered her too much, but I was a nice little boy. Mr. Jones, he has known Daddy for a long time and he pays special attention to me. The teachers? Ah, they're just fine! Each one seems better than the other one."

When asked how he got along with the children on the school grounds, he replied, "They call me names—'Four Eyes'. I don't want to say those other words. They say, 'Not worth a penny', 'Round nose', 'Crooked teeth'. And I gave him a good chasing for that and I don't like it. They call me 'sissy' and 'yellow baby', and I want to make friends with him. But some day they are going to get what they need. I don't want to be tough. Some day I may be a great man, and they'll want to come to me for help."

When Charles was asked if he were happy, his reply showed the secret of his troubles: "I'm happy most of the time. I'm happy for being a good boy and making my mother happy." Charles' attachment to his mother was of a dependent and infantile type.

Submission in a child may be due to other causes. Submission implies that the child has recognized his relative inferiority and has bowed to the inevitable. In the home, the child has been forced at some time to recognize his inferiority to the parent as to physical size, mental capacity, breadth of life experience, and power to punish. In some this inferiority finds expression in fear of parental authority. The child disciplined by slaps from an emotional and impulsive parent is apt to show this type of reaction. Fear of the parent may be transferred to the teacher. The common signs of fear are familiar to all, but fear may have indirect manifestations that may be misinterpreted. The child is usually ashamed of his fears, so that means of disguise are sought. An assumed boldness may successfully mask the underlying uneasiness from which he suffers. Fear is the great inhibitor. It tends to paralyze, not only the muscles, rooting us to the spot, but the thought processes as well. Bewilderment and mental confusion are generally accompanying phenomena.

When John was asked about his troubles at school, he said, "Once in a while, when I don't understand, I have trouble. I can't think what I want to say. I get nervous when I'm up before the whole class. I think I am going to make a mistake or something." John was always submissive and obedient at school, but his teacher considered him dull and stupid. A correct interpretation could be made only when his fear was understood. Questioning by the teacher produced confusion and failure of his thinking processes. As a result, he lost confidence in himself and came to believe, with the others, that he was stupid. We find him cringing, submissive, bewildered, and crushed in the presence of authority.

Fortunately for both pupil and teacher, the majority of children do not react to the pupil-teacher relationship in such an extreme manner. The adult seldom realizes the depth of feeling that is possible to the child. All of his reactions to authority are developed on a strong emotional basis. Some are activated by injury to self-esteem, others by fear, and others by anger. Some are used consciously, with full awareness of their purpose, but others have, from frequent use, become automatic habits of response.

Before discussing the opposite extreme, some of the other

reaction patterns developed in the child when confronted by authority should be considered. As the child's status in the home has been one of relative inferiority to the parents, his strategic reaction would be one of defense. The average child has developed a useful assortment of defense mechanisms by the time school age has been reached. Through these, many unpleasant stimuli and painful situations have been avoided. Correction or criticism is unpleasant to the child; it causes pain by lowering his self-regard.[1] A defensive attitude is assumed when his deeper feelings are touched. If he is suspected of some mischief, he may say, "What did you say?" or, assuming an innocent air, may ask, "Who? Me?" This gives him time to take his bearings, to judge of the mood of his accuser, and to prepare for the next question.

Excuses are a common defense. They are an attempt to give a reasonable explanation of failure, but to conceal the true causes that lie back of it. Such excuses are called rationalizations.[2] In this mechanism reason plays the traitor by helping the child to delude himself. Rationalized excuses serve two purposes. They preserve the self-regard from injury in case of fault and protect the child from the dictates of authority in case the fault is discovered. An excuse that is satisfactory and reasonable to the child is readily offered to some one else. To illustrate, Jack tells us, "I don't like arithmetic. It always gets my goat. Wednesdays I have to get corrective exercises, and she gives them problems, and when I come back, I don't get them and she blames me for it." Jack dislikes failure and has evolved a line of reasoning that places the responsibility for the failure on the teacher.

When Jack is asked why he ran away from home, he shows other methods of defense. "I don't run away from home some days." He does not answer the question directly, but answers a similar question which allows him to give a response more favorable to himself. His answer is irrelevant to the question asked. This method is frequently resorted to by a child on the defensive. Using a more advanced form of it,

[1] *An Introduction to Social Psychology,* by William McDougall. Boston: John W. Luce and Company, 1921.

[2] *The Psychology of Insanity,* by Bernard Hart, M.D. Third edition. New York: G. P. Putnam's Sons, 1919.

the child will make contradictory statements. This proves very confusing to the questioner.

There are several types of response that serve the purpose of defense and that can all be included in the term evasiveness. Some children become adept in completely ignoring questions, hoping that the next question may not require an answer so incriminating. Other children acquire a real art in changing the subject. In this way they avoid committing themselves. Even an intelligent adult is easily misled by such tactics.

The child learns very early to avoid stimuli and situations that he has found painful. If burned, his hand is withdrawn from the flame almost before he is aware of the pain. This movement is reflex in character and probably forms the basis for more complex reactions, such as withdrawing,[1] avoiding, and the flight reactions. In school, the cutting of classes and truancy are the common manifestations of this type of reaction. In a matter-of-fact way Fred told us, "I don't like cutting classes, but there's one teacher, he started out the term by giving me demerits when I didn't do anything. I had a scrap with him about it and only went to his classes two or three times after. I cut another class once because there was a test, and I didn't know anything about it. Another time I wanted an extra day to hand in a composition."

Complete flight from authority and from assigned and distasteful tasks is seen in some cases of truancy. It is generally associated with a strong feeling tone. When asked why he played hookey, Bert said, "I just like to be free. The work is kinda hard and they're making trouble for a fellow if he doesn't get his studies. They take him to the office and all that. I guess I worry more about school than anything else. It's just trouble all the time. If it ain't one thing, it's something else."

The use of the excuse, "I forgot", is probably the most common defense. Within certain limits, we remember the pleasant things in which we are interested and forget the uninteresting and unpleasant. In much of our forgetting we are not aware of the operation of this principle. We forget,

[1] *Social Psychology*, by Floyd H. Allport. Boston: Houghton Mifflin Company, 1924.

but are unwilling to admit any purposefulness in the process. In both children and adults this mechanism is in frequent operation. Some pretended forgetfulness is only an excuse. Asked how he liked his work at school, James told us, "I like arithmetic if it's not too hard, if you don't have to rack your brains to get it. I don't like to have to learn poems by heart at school. I forget them right away, so what good does it do to learn them?" This boy puts forth little effort and finds it unpleasant. He also brings his forgetting mechanism into operation and then uses his forgetting as an excuse for his inadequate effort.

Although all defense mechanisms are prompted by the emotions, there are some mechanisms in which the feeling tone so far predominates as almost to constitute the entire defense. Sensitive feelings can be effectively protected from injury by an assumed air of indifference, apathy, or boredom. Questioning can be discouraged by the indifferent reply, "I don't know, I don't know." Irritability may be used as a defense or to prevent further questioning. "I don't know, I don't know", spoken with increasing irritability will deter the questioner. An irritable, annoyed, or provoked tone is really a defense by threatening anger. It may be accompanied by "nervous" manifestations—twisting, restless, fidgety movements, or even the characteristic temper tantrum. Most so-called "nervousness" is defensive in purpose.

Blaming some one else automatically does away with the necessity of defending oneself; consequently it is a favorite method of defense. In the case of the pupil who blames the teacher, it approaches very closely to rebellion. Helen told us with vigor, "I didn't like my writing teacher. She's always getting after me for talking and not paying attention. If I didn't get my hand just right, she'd shove it over and mark my paper and then blame it onto me and give me five." Asked if she got a "kick" out of being bad, she said, "Sometimes I get a lot of kick, and sometimes I'm afraid. I'm afraid what will happen when I get caught." With Helen, fear is all that prevents open rebellion. She recognizes the spirit of conflict, and from it is deriving a satisfaction that should be obtained from her work. Her reaction is partly attack and partly defense.

Just as apathy and irritability may be used as defense mechanisms, so rebellion against authority may show itself by a mood. Surliness, sullenness, and stubbornness lend themselves to this interpretation. Neither words nor acts are necessary to show the antagonism. Refusal to comply is expressed by the mood alone.

Revolt against authority, if a habitual response, is a manifestation of serious egocentricity. Children who show this response are likely to make it whenever their desires are interfered with. They consider only their own feelings and desires. No idea or suggestion is acceptable to them that does not coincide with these. Situations are judged solely on the basis of self-gratification. The right to be a law unto themselves is taken for granted. Robert had told us he did not like to go to school. When asked why, he said, "'Cause I don't like it. I can't have no fun. The kids won't let me. If I come in late, the girls tell on me. I have to duck every time I see a teacher coming, 'cause they search me to see what I was doing. Mother thinks it's a nice school, but I think it's a razz." This was the boy's whole attitude toward life. He was out of step with everything and every one. On account of his continual effort to protect his over-sensitive feelings, he can never forget self. He has never known the pleasure of pleasing others.

Having indicated some of the ways in which the pupil may react to the teacher's authority, let us see what these various reactions have in common. First, the average child makes frequent use of many of these mechanisms. Second, they are seldom seen in a simple or unmixed form. Third, the greater their effectiveness, the surer they are to become life habits. Fourth, the reaction patterns are usually formed in the home during the pre-school period, but the teacher can modify them by intelligent treatment. Fifth, they are outward manifestations of deep and conflicting emotions in the child, occasioned by his inferior position. Sixth, they are efforts on the part of the child to compensate for this feeling of inferiority, and to protect himself from a further lowering of his self-esteem.

Can the study of exaggerated mental mechanisms found in atypical children contribute anything of value to the teacher's problem? It will help her to understand her most trying

pupils and suggest a technique for meeting this problem constructively and effectively. It will give her a better understanding of, a renewed interest in, and an added tolerance for all her pupils. It will help to bring a realization that, although each pupil is just one of forty or fifty, he is still an individual personality as well as a receptacle for knowledge. Mental hygiene has a real contribution to make to the teacher.

COMMUNITY ASPECTS OF CHILD GUIDANCE*

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EVERY child-guidance clinic has an individuality determined by its community; the common factors are familiar. The function of a child-guidance clinic has been defined as that of dealing with the personality and behavior problems of children as they arise in home, school, and community, and the distinguishing feature of a child-guidance clinic is the fact that its attack on such problems is fourfold, combining the professional methods of the physician, the psychologist, the psychiatrist, and the social worker. We talk also of the necessity for considering the whole child and not simply one phase of him. Unless we are careful, these may become catchwords of a trade. We use them so often that we run the risk of forgetting just what we mean by them. They have the glamour of sounding new and technical, whereas they express merely the familiar experience of all of us.

A child-guidance clinic actually does handle human nature in a slightly new way, but it is a late arrival on the scene and is dealing with a commodity that has puzzled and interested mankind since the beginning of time. Truly we know rather little about human beings when we consider the centuries that have been given to figuring them out and to learning to educate and direct them. They are more complicated than Einstein's theory and far more immediate and incessant problems. As a matter of fact, human nature is everybody's business and no one has ever been able to neglect it successfully, either in himself or in others. Parents have to reckon with it in their children, teachers encounter it in their pupils, and employers find it in their stores and factories. Governments and religions, schools and social agencies have all

* Read in part at the annual meeting of the Board of Directors of the Demonstration Child Guidance Clinic, Cleveland, Ohio, February 1, 1926.

resulted from the effort to bring it under control. They have their own special purposes, their own special methods, and their own traditions. They disagree and even work at cross purposes. But whatever their differences and deficiencies, they all handle human beings and must continue to handle them whether we have child-guidance clinics or not. Perhaps the most that the child-guidance clinic can claim as its contribution is the simplicity of its aim! It leaves to parents the job of raising children, to teachers the task of educating them, and to the church the problem of directing their spiritual lives. It recognizes that most of those who have to do with children have some special important purpose, while its major interest is limited to discovering what the child is and, through that discovery, to assisting others in doing their necessary job with him. Actually, each group finds itself blocked in its function by personality and behavior problems the source of which it is almost impossible to find. The teacher fails to teach a particular child because of some obscure and complicated difficulty in the home. Or the parents have trouble with him because they are preoccupied with the struggle for existence or handicapped by their ignorance of our language and customs, by ill-health or secret dissatisfaction with each other. Any single one of the succession of those who deal with the child in the course of his career has very small opportunity or power to handle those phases of his life which lie outside a special province. The result is that the average child remains a conundrum and that most of those who are responsible for him are thwarted because they never have a chance to see more than a fraction of him. Moving heaven and earth would be a simple feat compared with the problem the teacher faces in trying to straighten out those extra-school difficulties which make a child a nuisance in the classroom. As we see it, each agency in the community is forced to work more or less in the dark on problems controlled by situations beyond its reach. That is why the child-guidance clinic speaks of understanding the "whole" child. The attempt to do so is costly, for it involves exploring his entire universe. Probably it would not be worth while if we did not also attempt to convey what we know of the child's whole life to those who deal with each fraction

of it, so that they can see their own problem more clearly, work together with the rest of the community in a coördinated way, and formulate new methods in the light of a better understanding of the material with which they are working.

Child-guidance-clinic work has always excited an enormous amount of interest and has occasionally been the victim of the very publicity it so readily receives. To many people it has revealed a revolutionary point of view and the thrill of this has made them expect miracles. Revolutions never work out as easily or as quickly as we might hope. The source of the thrill is in the rediscovery of the child by those who have always seen him through adult eyes. The average child is an alien in our midst. We cherish the illusion that we understand children because we have all been children ourselves, but there are few adults who do not subscribe to the common myths about childhood. Most of us embalm our childhood in jokes or sentimental recollections of that period as the golden age. It is a shock to discover what the average child thinks and feels and to realize the discrepancy between his needs and our approved methods for meeting them. The implications of this new view of him as a developing individual can be appreciated only by those whose task it is to establish more suitable conditions for him in the home, the school, and the community. This could not be done in the twinkling of an eye even if we adults were willing to surrender all our present habits and prejudices, since it involves modifications of the whole of the community's complex machinery and the development of new methods of child training, education, and the like. The utility of child-guidance-clinic work certainly cannot be demonstrated within a period of a few years, since it depends on a slow, but progressive integration of all those activities which affect the lives of children. In the last analysis a child-guidance clinic accomplishes its purpose only as it activates in parents, schools, and community agencies a greater understanding of the individual child and a more sensitive and flexible handling of him.

There are very good reasons for calling a child-guidance clinic an experiment, for starting it on a small scale and dwelling on its limitations as an isolated agency. In the first place, a child-guidance clinic is doing preventive work and

preventive work always seems an extravagance to a public that is heavily taxed by the expense of controlling crime, caring for the insane and the feebleminded, and wiping out disease. *These* are problems that strike home, inspire fear in any one able to read a newspaper, and worry us all because we have nowhere succeeded as a community in dealing adequately with them. They take precedence in our minds because they are dramatic enough to occasion newspaper crusades, to interest political machines as party issues, and to raise a general hue and cry about emergency measures. They have to be provided for just as dangerous waste products have to be removed to keep the wheels turning. The institutions that care for them receive and should continue to receive first consideration, for they are questions of universal concern and individual protection. But just as in the case of tuberculosis, treatment of the disease first began with recognition of such final symptoms as a sepulchral cough, emaciation, and hemorrhages and then advanced until prevention became part of the general hygiene of the whole community, so we feel that psychiatric work with the early difficulties of children will gradually relieve us from the human wreckage which at present impedes our progress.

I have not meant to indulge in prophecy. The work of a child-guidance clinic is slow and its development remains in the hands of the community as a whole. As a functioning agency, the clinic cannot afford a proud independence. Its life depends on its assimilation into the organized community. It must patiently build up relationships with groups whose heavy responsibilities have made for their isolation. To be effectual, the clinic must establish functional connections with such agencies as the schools, churches, case-working societies, courts, and institutions which deal with a thousand children to its one. It cannot now and probably never will operate on any wholesale basis. It can enter directly into the lives of only a limited number of children and for this reason will always be a relatively expensive agency. As a separate entity, it is at most only a small laboratory working with a few children, but working with them in a more comprehensive way than any other organization. Its justification lies in its capacity to give those interested in children a fuller picture

of all that children are, think, and feel, and in its ability to make them conscious of the whole child and the whole situation, since these so often elude the specialized agency. Intimate communication with other groups is a necessity for the clinic, because its methods of treatment are largely derived from allied fields and depend for their development on the clinic's knowledge of and coöperation with all those who share its interest in the problem individual. Treatment means working out with parents new methods of child training, with schools modifications of teaching practices to meet individual needs, with social agencies case-work techniques that will penetrate to the core of the difficulty. It can furnish other agencies new data and fresh points of view, but the value of these can be proved only as they are absorbed and applied. For the child-guidance clinic the question is one not only of giving, but of receiving. Its technique has developed only as it has better understood the purpose and methods of other agencies and has worked in sympathy with them. Its methods are composite and are frankly drawn from every available source. It has to learn the language of all the agencies that are an influence and convey to them a working knowledge not only of its purposes and methods, but of its dependence on them for coöperation in treatment. In the life of the community the clinic represents a service for the exchange of ideas and the evaluation of methods.

The child-guidance clinic has no final solutions to offer in the treatment of personality and behavior difficulties. This is true, of course, partly because child-guidance-clinic methods are derived from sciences which are still developing, and also because treatment actually depends on the coöperation of other agencies which are themselves in various stages of evolution. The child-guidance clinic has no magic formulæ and is not yet in a position to supplant parents, teachers, judges, and others who up to this date have felt some responsibility for leading the child in the way he should go. It is quite content to have them continue in their present rôles and is modestly interested in giving more power to them since its own effectiveness depends on the healthy growth of their functions and the possibility of their developing resources complementary to its own.

I am very suspicious of dramatic developments in the child-guidance field and believe that real progress is an intangible not to be weighed and measured. What has struck me as really the most substantial evidence of achievement is the spread of ideas derived from psychiatric work with children into the personal codes of intelligent parents; the interest of educators in applying to the problems of grading and curriculum insight drawn from the same source; the eagerness of social workers for whatever ideas they can get from clinical practice. This means that allied groups feel that they can accept and put to their own uses a point of view and a technique which otherwise might be limited to child-guidance-clinic cases. It also gives us reason to believe that whatever we have to offer will gradually penetrate to every recess of the community and in a truly preventive way modify those trial-and-error methods which are at present producing personality and behavior difficulties.

PSYCHIATRIC EXAMINATION OF A CHILD*

PREPARED BY THE DIVISION ON PREVENTION OF DELINQUENCY OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

THE success of the examination will depend very largely on the child's reaction to the examiner and his notion of the examiner's attitude toward him. As children are frequently prejudiced or intimidated by what they have heard about the clinic and imagine that the psychiatrist is an arm of the law or an abettor of school or home discipline, it is well to ask in each case who the child thinks the psychiatrist is and what he thinks the clinic is going to do to him. A frank and friendly explanation of the clinic's interest will help to correct any defense reaction the child may have.

The psychiatrist should carefully guard against giving the child the impression that he is chiefly concerned about investigating his misbehavior or delinquencies. An attempt to make the child confess a series of faults to an utter stranger gives him a wrong idea of the clinic's purpose and tempts him to lie about matters he might freely discuss if he were attacked less directly. If the psychiatrist does not impose on him the burden of confessing, but takes for granted all the known aspects of the child's difficulties, the child is more apt to see that he is dealing not with a partisan, but with a friend who knows the worst about him and is still a friend. The main emphasis should be put on the real psychiatric issues of how the child feels about the conditions to which he does not adjust, what elements in the situation affect him most, what responsibility he assumes for his difficulties, and what he himself thinks would straighten out his entanglements. The experience of talking over his troubles with an adult who recognizes his point of view, who is not primarily

* The instructions given in this paper are merely suggestions for psychiatric study and are not exhaustive or final. The social history and the physical and psychological examinations should in each case furnish other important leads. The paper is reprinted from the *State Hospital Quarterly* (New York), August, 1925.

interested in the detection of guilt or the infliction of discipline, but who simply wants to help him out of his difficulties, has often an unexpected therapeutic effect and in any case gets the child's confidence.

The form of examination should be molded as much as possible to the peculiarities of the individual case. For this the social history should furnish a rough guide to the psychiatrist. In questioning the youngster he should not simply take another family history, but should first study the social history and in the light of that explore the child's attitude toward himself and his various reactions to the described family, school, and street situations. It is important to know how conscious the child is of his difficulties, what he considers to be his main troubles, where he puts responsibility, how he feels about his special weaknesses and failures, and what needs he is trying to satisfy by unwholesome behavior. Unless the social history is used to guide the child through the main patterns of the child's life, his responses will often miss the mark at which the examiner is aiming, for a child has little power of interpretation, often fails to make significant connections, and is seldom sufficiently oriented about himself to answer a mere questionnaire relevantly. A series of general questions, because they are not adapted to the individual's special experience, may make him feel that the psychiatrist is merely putting him through a routine inquisition, instead of discussing *his* problems with *him* from *his* point of view.

TOPICS OF EXAMINATION

One of the most important lines of inquiry is that into family relationships. The social history will have revealed some of the possible sore spots—a divided household involving a conflict in the child's loyalties; a step-parent of whose existence he is jealous or whose discipline he resents; a mother whose death or absence he cannot resign himself to; a parent whose severity makes the child feel that he is not loved; parents of whose bad habits or unethical behavior he may secretly be ashamed; brothers and sisters who are brighter or better adjusted or more popular than he; a younger child who has supplanted him; an older child who disciplines him; and so forth. Often there is no definite indication in the history

of an emotional involvement and only the existence of a provocative situation will give the psychiatrist a clue to the central difficulty with which the child is unsuccessfully coping. The psychiatrist, even in the course of examination of these family entanglements, is helping the child to see objectively relationships which he may never have discussed before and thus giving him a chance to express his feelings and to grasp the point of view of others in the family. The mental examination should reveal to the psychiatrist not only the distortions in the child's point of view which must be corrected, but also the harmful attitudes and exactions of the family which can be regarded as avoidable causes of the child's maladjustment. In this connection the psychiatrist should let the child feel that as much attention will be given his side of the story as has been given that of the adults.

School relationships are a second important field of study. Examination should touch all the subjective aspects of the child's school reactions—whether he likes school, when and for what reason he began to dislike it, what subjects he likes or dislikes, whether he likes or dislikes his teachers, whether he feels he is fairly treated, whether he feels he is responsible for his difficulties or blames his teachers and schoolmates, whether he appreciates his mental abilities or deficiencies, whether he is ashamed of his intellectual disabilities, whether he gets along with the other children or feels insignificant, inferior, or an outcast. If his attitudes are later to be corrected, it is important, in going over these points with him, to find out just how much insight he has, on what sensitive spots pressure could readily be relieved, and in what respects he is most accessible to readjustment. An incidental function of the examination is to help him see his school situation realistically, to get him to face the necessities of school adjustment, and to supply him with some notion of the reasons for demanding this adjustment of him.

In covering the routine topic of habits the psychiatrist should take the precaution of finding out whether the child has been shamed or frightened by adults anxious to cure him of enuresis, masturbation, or the like. It is worth while, when there is a history of such habits, to present casually to the

child a point of view free from moral condemnation and medical threats.

Inquiries should be made into the child's dream life, as his dreams often give us an insight into his desires, his fears, or his conflicts. The child's fear attitudes are important as well as his other emotional responses, whether of concrete punishing forces or such things as ghosts, and so forth.

The social history should again furnish the psychiatrist with an economical guide for investigating the child's interests and discovering what satisfaction they give him. This inquiry should throw light on the amount of recreation actually provided for him as well as the substitute satisfactions he has found for the lacks in his environment. His vocational ambitions are a related subject of great importance since they reveal not only the trend of his interests, but his estimate of himself and his possible ignorance of the realities.

The child's social relationships, his needs, abilities, and aspirations are another important phase of his problem which are best approached in a discussion of the social activities and companions described in the history. Is the child a leader or one of the led; does he feel inferior because he is physically weak, colored, Jewish, Italian (etc.), cowardly, poorly dressed, awkward, red-headed, or retarded? Is he called uncomplimentary nicknames and does he feel "picked on"? Does he feel unpopular and what makes him feel so? In this concrete connection some of his personality difficulties may be mentioned—his bad temper, failure in team play, love of limelight, habit of teasing or tormenting others—qualities revealed in the history and examination, but of whose existence he may not be aware in terms of their detrimental social effects.

The child's attitude toward the opposite sex and his sex knowledge and practices should be delicately investigated lest his interest be excited or his possible conflict deepened. Perhaps an approach to sex topics might be made while discussing the child's companions. He is often more willing to repeat "bad" words he has heard used, or to describe things he has seen others do or heard them tell about, than he is to discuss his own personal experiences. His manner and definiteness in reporting concerning his friends will give some indication as to how far his own knowledge and experience

extend. What does the boy think of his sisters, of girls in general, and so forth? When the child has engaged in sex activities or delinquencies, it is important to discover whether he has any emotional conflicts and whether he is aware of the social significance of his behavior.

In the case of other delinquencies, the psychiatrist's main effort should be directed toward keeping the child's confidence and of not allowing him to connect the psychiatrist with any fears of punishment. The child should realize that confession is not the chief objective of the examiner; that the latter already is fairly well acquainted with the facts and that his principal interest is a sympathetic inquiry into motives and provocations. However, if, according to the social history, the child will not admit his responsibility for the delinquencies under discussion, the psychiatrist should take care not to take any moot points for granted, but to receive information with judicial friendliness. The child's motives in the delinquency, his appreciation of its seriousness, his sense of responsibility, his possible shame or dare-devil pride, the physical and psychic needs he satisfies should be the important questions in the mind of the examiner.

In his summary, the psychiatrist can give briefly a tentative estimate of the child's motivating mechanisms, the degree of his insight, his resources for adjustment, and remediable difficulties in the environment.

OUTLINE FOR THE PSYCHIATRIC EXAMINATION OF A CHILD

Introductory statement:

The chief purpose of the psychiatric study is to obtain as intimate an understanding as possible of the child's own thoughts and feelings about himself and the various situations with which he is confronted. The aim should be to *grasp his point of view, to understand his attitudes.* The cues for discussion should be obtained from the social history, and the problems entered into in a friendly and sympathetic manner, with no indication of reproof. Embarrassment or reticence concerning any subject should be met by a matter-of-fact tone and manner on the part of the examiner. The following suggestions *will serve as a guide* for further questioning and study.

Play life and other interests:

(Interest analysis blanks will be helpful here and should be used unless used under psychological.)

Does he prefer to play by himself or with other children?

What type of play—active or passive games? Give details.

What other interests has he in addition to those usually considered play?

Is he a leader among his playmates?

Does he earn any money and what does he do with it?

What work does he do at home?

Dream life:

Of what does he dream? Tell dreams in detail, especially of home, school, fear, or other nature?

Does his dream life suggest dominance by emotional conflict or disturbance of any kind?

Does he daydream? What about? Any nightmares or sleep walking?

Fears and emotional conflicts:

Of what things is he afraid? Describe in detail origin, character, etc.

What is his attitude toward sex matters? Any repressions or conflicts associated with this field?

Are there indications of any feeling of inferiority with compensating mechanisms?

Attitude towards situations or persons, and enuresis, masturbation, stuttering, etc., if present?

Attitude toward body:

Any complaints? What? How long? Describe fully.

Ever faint or feel dizzy?

What is his attitude or interests towards his bodily functions and personal hygiene?

What are his habits in eating, sleeping, etc.?

Attitude toward school:

Does he believe that he gets along well or poorly in school and why?

Does this compare with the reports from the teacher?

Does he like school? If not, why?

What is his feeling toward his teachers? Classmates?

What are his scholastic ambitions?

Attitude toward companions:

Is he a "good scrapper"? How does he get along with companions?

Does he get angry with them? Does he feel that they tease him too much?

What does he think about his companions—that they are good or bad?

Has he learned bad words or bad habits from them?

Does he prefer companions of the same or opposite sex, and why?

What special chums? What do they talk about?

Attitude toward family situation:

Is he punished or teased much at home? Does he deserve it?

Does he like best his father or mother and why? Who is his favorite in family and why?

Does he feel that he or another child is the favorite?

What are his feelings towards his brothers and sisters?

Are there other relatives whom he particularly likes or dislikes?

Attitude toward misconduct or bad habits:

What has he to say about his difficulties?

Try to get him to work out the beginnings of his offenses, habits, etc., and give details as to his first experiences in lying, stealing, or sex experiences.

Is there anything in his life which serves to explain his bad conduct?

Is he defensive, honest, etc.?

Attitude during interview:

What special attitude or reactions during examinations?

Attitude toward examiner?

Is he self-conscious, ill at ease, restless, flighty?

Does he flush easily?

Is he boastful, "smart Alec," etc.?

Is he indifferent or apathetic?

Does he enter into the spirit of the occasion?

Note:

Certain cases will call for special inquiry into memory fields, orientation, etc., especially when related to organic processes and also where the question of consciousness is involved.

Peculiar ideas, delusional trends, phobias, and other unusual manifestations found as a result of social history or observation should be carefully followed up.

SOCIAL ADJUSTMENT OF MORON GIRLS

ELEANOR ROWLAND WEMBRIDGE

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FOR approximately half of the time since its founding ten years ago, the Women's Protective Association of Cleveland, Ohio, has operated its own mental clinic. It has given mental examinations to about 2,100 girls, their relatives, and friends, and since many of these examinations revealed more or less serious mental retardation, it has seemed desirable to study our successes and our failures with some of the mentally deficient cases, in order to learn what likelihood there is of our being able to establish any of them safely outside of institutions. Granted the great capacity for harm that the feebleminded girl possesses, what, if any, seem to be her chances for social adjustment and creative work?

This paper does not aim to be a statistical report. Nevertheless, we give a few figures to show the background of our study. If the 2,100 cases examined are charted, there are found to be 918 with I.Q.'s of 80 and over, and 1,182 with I.Q.'s from 79 down. Of these, 565 have intelligence quotients under 70 and are considered feebleminded, of all grades from high to low. This means, therefore, that 56 per cent of our work has been with the duller grade of girl, not advised by the board of education to attempt high school and finishing the grades only with the aid of "slow-moving" classes or "over-age groups". It means, further, that 26 per cent, or a quarter, of the work has been with cases who could not keep up with the regular grades by any device, but would have to be placed in special schools if their education were to be continued.

The reasons for which girls come to our organization are various, but they can be grouped roughly into the following classes. The delinquent types come or are sent to us for sex offenses, larcencies, incorrigibility, and running away. The non-delinquent types are brought, or come voluntarily, to get employment, because of family difficulties, and for advice,

often vocational in character. Of course these classifications, or any others that we might select, overlap, and most girls could be included under several, many under all of these headings. But in listing the 1,519 cases from 1923 through 1925 according to the special emergency that brought the girl to us, or the major feature in her problem as we saw it, the average intelligence quotients ran as follows:

Number of cases	*Reason for reference*	*Average I.Q.*
421	sex problem	74
198	runaway	78
258	larceny	79
210	family difficulty	79
247	employment	79
121	incorrigibility	80
64	vocational advice	90
1,519		

Although all our averages run low, and there is little difference among some of the groups, it is evident that those whose problem is mainly a sexual one tend to be at the lower end of the list, while the more active offenders average higher, and those who came voluntarily for advice register highest of all. The average I.Q. for all of the girls for the four and a half years during which we have been giving mental examinations is 77, and our experience, in line with that of the city board of education, is that the usual employment for girls of this grade of intelligence must be that of the factory, the restaurant, the kitchen, the laundry, the more routine types of office work, or the selling of the simpler commodities. This is our average. And what of those who fall below even these modest demands? What have we a right to expect of our 565 girls below 70, of our 193 below 60? What do we actually get, and what have we a right to hope for?

The practical situation in our city as regards the courts is that they are ready to commit people with an I.Q. below 70, and sometimes slightly above that figure, to a school for the feebleminded, provided the parents or guardians will agree to such commitment and will institute no defensive lawsuit. However, because of the crowded condition of the schools for the feebleminded, the selection of recruits is made first from those girls of low intelligence who have showed

marked delinquent tendencies, especially if they have had one or two illegitimate children. Even with the utmost coöperation of judges, therefore, there remains the large proportion of feebleminded young people who must be permanently adjusted to society outside of an institution, or at least rendered harmless pending a possible future commitment. It is our experience, as it is that of many other organizations, that many can be so adjusted. The question is: How and when can it be done, and what is a fair prophecy of success in the future, or a proof of success when attained?

As to the statistical chances of success, the writer feels that she can hardly give an answer, because the statistics of any organization such as ours must necessarily be incomplete. We deal with a population much of which is floating both as to individuals and families. Absence of any specific information that our girl has failed to adjust cannot be fairly called success, and yet it is often exceedingly difficult to get adequate reports of final success or failure, because of the fact that the individual may have left the state or the county, or have buried herself in some remote district or foreign-language-speaking group in the city, from which expert detective work, for which we have no equipment, would be required to get accurate reports. The success or failure of many, therefore, must remain unknown until time or circumstances brings them again to view. Instead, therefore, of a statistical study, with a coefficient of probability which our figures scarcely warrant, we have taken for discussion 25 cases of girls, of various levels of feeblemindedness, who have been, at least for the present, successfully adjusted to society, and 25 cases of girls of the same grades of intelligence who have not been so adjusted. We selected these cases from the files at random, discarding only those whom we have known too short a time to be sure that they had either succeeded or failed. In future years, there may be shifts from one group to the other in both directions, but wherever possible, we have selected cases of from three to four years standing, in which purely temporary success or failure would not weigh against more lasting results. Our idea of adjustment is indicated by the following rather modest demands: To be called a success, the girl must either be supporting herself or be supported

by some legitimate person; she must satisfy reasonable family and court requirements as to behavior, and must be in such physical condition that she is not a menace to public health. The non-adjusted cases are girls who refuse to be self-supporting or to get support from legitimate sources, whose behavior resists improvement, and who wilfully remain health menaces to society, unless forced to institutional care.

The object of this paper is not to prove how efficient our organization is in turning morons into useful citizens, but, on the contrary, by a study of a number of successes and an equal number of fairly obvious failures chosen at random, to analyze the conditions that prevail when we succeed in helping and when we apparently do not. An outline of the main facts in our 50 cases follows:

SUCCESSFUL ADJUSTMENTS

	Age	*I.Q.*	*Circumstances*	*Outcome*
1.	17	69	Larceny. No sex problem.	Is paying back what she stole. Family sympathetic. Engaged to marry.
2.	15	69	Runaway. No sex problem.	Father has been frightened into good behavior. Employment in grocery.
3.	16	68	Runaway from scolding parents and employer. Attempted suicide. Immoral, but not promiscuous.	Housework job. Y. Club. Bank account.
4.	18	68	Family cruel. No sex problem.	Moved away from family. Hospital maid. Boarding home.
5.	18	67	Unsteady employment. No sex problem.	Laundry job.
6.	16	66	Family cruelty. Not immoral.	Married.
7.	16	66	Immoral promiscuously. Father a pervert; mother has good standards.	Married after two years at industrial school.
8.	16	63	Low-grade family who demand all girl's wages. No sex problem.	Factory job, supervision. Help with money affairs. Engaged to be married.
9.	16	63	Family unsympathetic; stepmother. No sex problem. Feels superior to family.	Works in store basement.
10.	21	63	Spinal curvature, birthmark. Immoral with one man. Has an illegitimate child.	Works in maternity hospital and keeps very pretty baby.
11.	20	61	Bigamy. Ignorant, but good-natured and a hard worker.	Two years in an institution. Now at large and respectably married third time.

	Age	*I.Q.*	*Circumstances*	*Outcome*
12.	16	61	Forgery. No sex problem. Household drudge; no spending money; no finery.	Housework. Final arrangements with family to be that she has spending money. Is receiving training in how to shop and bank her money.
13.	16	61	Scotch immigrant. Irresponsible worker; silly with boys.	No proven immorality. Affiliated with Scotch people. Intensive training in accounts and banking. Buys return ticket to Scotland.
14.	19	60	Suffered sex assault as child; incest. No training in anything.	Trained in housework by relative. Lives in country. Married farmer.
15.	16	60	Prostitute in hotel six months. Gonorrhea.	Housework with kindly old couple. Starts bank account. Hospital treatment. Engaged to marry.
16.	21	59	Immoral with one man. Has illegitimate child.	Never promiscuous. Hard working in restaurant job. Very proud of child; supports him.
17.	17	59	Good-natured and silly with boys. Poor worker, and conspicuous in behavior. Slow.	Housework with non-exacting housekeeper and four children with whom she plays. Has young man friend.
18.	18	57	Promiscuously immoral with her father's employees.	Marries one of them and lives with very careful and prosperous parents.
19.	18	56	Ran away because father drank and took her wages. No sex problem.	Earns $14 in woolen mill, and pays board at home. Helps support family.
20.	21	52	Awkward country girl. Has illegitimate child. Not promiscuous.	Marries paperhanger (I.Q. 63) and lives with his mother.
21.	16	51	Indiscreet and silly. Immoral, but not promiscuous. Attempted suicide.	Factory work. Lives at home. Probated to feebleminded institution, but is allowed outside on good behavior.
22.	33	51	Accomplice in theft of bonds which she did not understand. Deserted husband and immoral with thief of bonds.	Housework job and saved money for divorce. Bank account. Ready to marry man when out of the penitentiary.
23.	17	50	Childish. Mother dead and she keeps house for father and sister. Very protected. Never immoral.	Marries a sailor and keeps house for him when in port.
24.	17	47	Forced to marry by family. Ran away with another man. Not promiscuous. Good-natured and a good worker.	Was helped to get a divorce and to become a waitress in hospital. Remarries respectable man.

	Age	*I.Q.*	*Circumstances*	*Outcome*
25.	20	46	Bigamist, and her second marriage married a bigamist. No judgment in money affairs.	Was helped to get a divorce. Now is kitchen assistant in school under close supervision of friendly teacher.

Average age, 18.

UNSUCCESSFUL ADJUSTMENTS

1.	21	72	Promiscuous sex delinquency. Father and mother the same. Trained to prostitution in childhood. Both venereal diseases.	Committed to feebleminded institution.
2.	16	72	Prostitute. Older sister the same. Defended by weak, inefficient mother. Has an illegitimate child. Won't work.	Committed to women's reformatory.
3.	18	71	Country girl with foster parents. Has an illegitimate child. Claimed rape. No interest in child. May be neurotic case.	Ran away and deserted child.
4.	16	68	Stole from employer. Vagrant. Promiscuously immoral. Twice suicidal attempts by hanging. Father cruel. Neurotic type.	Committed to industrial school. Ran away and was recommitted.
5.	18	68	Promiscuously immoral. Both venereal diseases and refused treatments.	Committed to reformatory. Got out and has had one illegitimate pregnancy since.
6.	17	67	Runaway. Deceitful. Congenital syphilis. Mother a bigamist; left girl five years in institution.	Committed to feebleminded institution.
7.	21	67	Charged to others' accounts. For two years was mistress of employer. Syphilis. Attempted blackmail on him.	Common prostitute.
8.	18	67	Began promiscuous immorality young. Gonorrhea. Won't work.	Left state, boasting of sex exploits.
9.	18	67	Promiscuously immoral. Assaulted by father at twelve years. Divorced from husband. Reinfected with gonorrhea after cure.	Common prostitute.
10.	16	66	Started prostituting at fifteen. Very weak physically. Both venereal diseases. Has an illegitimate baby with syphilis.	Unable to work enough to support self or child. Committed to feebleminded institution.
11.	14	66	Family of clannish bootlegging gypsies. Immoral at fifteen with older man. Lives in filthy shanty constantly raided by police. Gonorrhea.	Committed to girls' farm.
12.	12	66	Low-grade family. Surly. Won't work. Illegitimate baby by elderly one-armed man.	Committed to feebleminded institution.

	Age	*I.Q.*	*Circumstances*	*Outcome*
13.	17	65	Truant. Immoral before fourteen years. Six years in orphanage. Mother immoral and father living with common-law wife. Poor physical condition.	Committed to feebleminded institution.
14.	18	64	Promiscuously immoral with boys in home, permitted by mother, who was prostitute, and witnessed by younger sister. Two feebleminded brothers. Bad health. Gonorrhea. Paternal parentage unknown by mother.	Committed to feebleminded institution.
15.	20	64	Promiscuously immoral. Married and left man she knew one day. Lived with man who produced abortions on others. Proud of her exploits. Gonorrhea.	Common prostitute.
16.	23	63	Raised in orphanage. Sister adopted and she was not. Surly and lazy. Both venereal diseases, but refuses treatment.	Common prostitute.
17.	17	63	Reared in orphanages. Entered vaudeville at fifteen. Parents indifferent and won't have her at home. Both venereal diseases. Almost blind.	Committed to Pennsylvania institution and ran away.
18.	16	63	Promiscuously immoral. Illegitimate baby at fifteen years. Mother refuses to care for her.	Committed to feebleminded institution.
19.	16	61	Promiscuously immoral before she was fourteen. Refuses to take it seriously. Family won't have her at home. Gonorrhea.	Committed to convent training school.
20.	26	56	Married at eighteen and again at twenty-two. No sex standards; always immoral. Second husband has I.Q. of 99, but is a neurotic, suspected of sex perversion, after fifteen years in navy.	Committed to feebleminded institution after repeated vagrancy, immorality.
21.	18	56	Promiscuously immoral. No family feeling. Won't work. Conspicuous and silly behavior in public. Gonorrhea.	Committed to feebleminded institution.
22.	19	56	Promiscuously immoral. Vagrant. Boasts of her behavior. Glass eye for infected eye. Gonorrhea.	Committed to feebleminded institution.
23.	18	59	Parents drank and deserted her. Lived with father of illegitimate child, and then married man whom she later deserted. Vagrant. Gonorrhea.	Committed to feebleminded institution.

	Age	*I.Q.*	*Circumstances*	*Outcome*
24.	25	47	Common prostitute. Raped when eight years old. Both venereal diseases. Six years in institution. Conspicuous immoral behavior.	Recommitted to institution.
25.	17	44	Promiscuously immoral; lazy; vagrant.	Commitment pending consent of family.

Average age, 18.

To summarize, of the 25 successfully adjusted girls, 9 presented no sex-delinquency problem; 16 had been sexually delinquent, but 10 of these not promiscuously. Two were known to have venereal disease (gonorrhea). Sixteen came from families with sufficient family feeling to coöperate with them and with us in helping them to adjust, and 9 were unable to coöperate with their families, but were able to adjust when living away from the family.

Of the 25 cases in which adjustment was unsuccessful, 1 presented no problem of sex delinquency; 4 had been sex delinquents, but promiscuity was not proved; and 20 had been promiscuous from their early teens or younger. Nineteen were known to have venereal disease—10 gonorrhea, 3 syphilis, and 6 both. Two had coöperative families; 4 had no family ties; and 19 had families as unadjusted as the girls themselves and wholly uncoöperative with them and with us, normal family feeling being completely lacking on both sides.

An analysis of these 50 cases seems to indicate that an early acquaintance with promiscuous sex relationships is the most serious drawback in rehabilitating moron girls. One unfortunate love affair a moron girl can apparently survive, as normal girls do. But the settled habit of sex promiscuity early established not only makes normal family relationships difficult later, but has perhaps a still more serious effect upon wage-earning life. It is a dangerous matter for any wage earner to become accustomed in early life to luxuries which his wages cannot legitimately afford, and it is very much harder for any one to lower a standard of living, once attained, than to remain on an economic level from which he has never risen. Even more than any direct satisfaction which these girls may get from their sex promiscuity is the standard of living, not based upon the earning of legitimate wages, which it entails. It means joy rides and shows, late nights in the

street and late mornings in bed, rather than steady work, early rising, and a good proportion of days and nights in which nothing very thrilling happens. Unless these girls can be early accustomed to simple pleasure and inexpensive amusements, they are likely to insist on having luxuries by the only possible means by which they can get them—that is, by prostitution.

Another obvious fact is that morons, like other people, are dependent on close family feeling. They depend upon their mothers' affection, their loyalty to their brothers and sisters, and some romantic feeling, however simple, with their sweethearts. If the usual family ties that keep any one's emotional life serene are denied them, they have no other outlets or substitutes, and are helplessly dependent on whatever their environments may offer.

Our conclusion is perhaps the obvious one—that the feebleminded share the fundamental emotions with the normal, depend upon affectionate family ties, patient friends, and discipline during their adolescence, and must somehow learn to recognize the fact that luxuries that cannot be afforded must be foregone. With the low earning capacity which mental retardation entails, the moron must learn to do without the expensive dress, the joy rides, the leisure, the ornamental and luxurious devices, the fancy food, the vacations, the social prominence and expensive entertainment which she sees others enjoying. Moron girls, as well as normal ones, can supply these lacks to some extent by promiscuous sex life, and having done so in early life, before adequate sex inhibitions have been established, they are impatient of drudgery afterwards when sex laxity is so much easier and better paid. Moreover, their lack of imagination weakens such deterrents as social ambition, fear of disease, and desire for self-betterment, which may operate with girls of similar vicious training, but greater mental capacity.

In this connection it has been interesting to study the six promiscuously immoral girls who, despite the handicap of early sex habits and low mentality, have yet apparently made good. In every case it is apparent that some emotional need was gratified which made up to them for what they sacrificed in abandoning their lax habits. A. was from the country,

and had prostituted six months only, in the city. She was placed with a family of her own social level who regarded her as a daughter, were demonstrative in their affection, and taught her to save her money. They also provided a home where she could meet an honest sweetheart, and her own sister often invited her to her home and encouraged her in her new way of life. B. had a mother with good standards, although her father was pronounced a sex delinquent. The girl was pretty, and had nice manners and a certain social ambition, which, combined with excellent training at an industrial school, made her want to belong to her mother's rather than her father's social class, and caused her to appeal to a husband who was her superior in ability. C. had been slightly promiscuous, but largely from ignorance. She was of the hard-working domestic type, had never acquired luxurious tastes, and after reformatory training, she much preferred to exercise her housewifely talents and live with one man in a home to indulging further in vagrant habits which had never been her real choice. D. had never been proven immoral. She merely liked to romp and be childish and silly with any one she saw. Placement in an indulgent private home with noisy children seemed to satisfy her. E. and F. succeeded because, despite their lax habits, they had guardians intensely interested in them—E. her own parents, and F. a teacher—who were willing to spend time in overseeing them and keeping them out of trouble. Although not in institutions, their care was of the custodial type, with affection added.

It was noticeable that the promiscuous sex delinquents tended to be as lax in their codes of hygiene as of behavior, and despite venereal disease, were very stubborn against taking treatment. For this reason, if for no other, they were an active public menace. We might infer from an analysis of these fifty cases that when a moron girl has interested relatives or friends to care for her, and to protect her from premature sex life and from disease, and when they will coöperate in affectionate treatment, there is a good chance of successful placement even with serious mental retardation. Where depleted health is combined with vicious and indifferent family life, and the luxuries obtained through prostitution, as against hard work, have been too early a habit, our

chances of placement outside of an institution are very meager.

In closing, however, it can hardly be denied that success, no less than failure, has its dangers to society. Part of the emotional adjustment of the deficient, as of the normal girl, is courtship and marriage, and we find that our successful moron girls almost inevitably marry and have children. Her unsuccessful sisters in the institution are not breeding, but she is. Whereas there must always be a lower level of intelligence in any society—some must be the dullest, whatever the standard may be—the general social question remains: If the successful moron girl is mating with the moron boy who in turn is successful enough to support her, is the next generation better or worse off than if they had all been total failures and incarcerated for life before their family was born? The writer believes that if institutions were adequate, placement outside might be a doubtful gain unless the birth rate of those outside were checked. But granted the fact that institutions are nowhere adequate to admit all those on their waiting list, and granted that those outside, whether successful or failures, are breeding their kind in any case, there is little doubt that the sum total of human safety and contentment is increased by non-institutional training of moron youth in moderate habits, self-support, and family happiness before they have acquired a false standard of living which they have not the mental capacity to readjust.

EDUCATING THE DEPENDENT CHILD*

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FOR the past seven years, The Church Home Society, the child-caring agency of the Episcopal Church of Massachusetts, has been testing the intelligence of the children under its care and trying, during the latter part of that time, to shape its plans for their education, to some extent at least, according to the need of the individual child as indicated by the tests. It now seems time to study the results of that experiment, to see how far it has succeeded and whether practical conclusions can be drawn that will make the educational work of the society more satisfactory. One hundred cases have been selected for study. They are children of sixteen years or over who have left school while under our supervision or are still in school. Needless to say this is but a small number of the children who have passed in and out of our care during the seven years in question, but in order to have a sufficiently uniform group for study, it has been necessary to eliminate all whose complete school records at sixteen are not in our hands and whose school advantages have not been regular and similar. A few eligible cases have been omitted in order to keep the number at an even 100. The sixteen-year age has been made a condition of inclusion because it is now generally considered that "the development of native intelligence seems practically to cease not far from this age . . . It has been found that after fifteen or sixteen, the mental age increases little, if at all."[1] At sixteen, therefore, providing the school experience has been regular, it would seem that we ought, from the actual progress a child has

* Grateful acknowledgment is made to Eleanor A. McC. Gamble, Wellesley College, for helpful suggestions as to arrangement of the statistical summaries, and to Louise Barker, psychologist, Boston State Hospital, for assistance with the statistical work.

[1] *The Intelligence of School Children*, by Lewis M. Terman. Boston: Houghton Mifflin Company, 1919. P. 129.

made, to be able to form some estimate as to how much farther he is likely to go. Prediction of school achievement with a reasonable degree of certainty has been found to be possible at a much earlier age, owing to the constancy of the I.Q., but since it is our aim to arrive at independent conclusions from the facts shown by our own cases, we must, for the moment, keep away from speculative considerations. The question of the constancy of the I.Q. will be touched later on in this paper. In addition to the foregoing criteria of inclusion, all cases must have had at least one psychometric examination by the Stanford-Binet scale, made by the same examiner. Many have had several examinations, and a few different examiners.

The cases were divided into two main groups—A, those considered to have high-school ability (I.Q. 90 and over), and B, those considered to have less than high-school ability (I.Q. less than 90). Each group was then subdivided into (I) those who graduated from high school, (II) those who did not, and (III) those who were still in school at the close of the school year, June, 1925. Those in the A group who did not graduate were studied to discover the most apparent reason for their not graduating, and those still in school in both the A and B groups were studied to see whether they fulfilled their I.Q. expectation.[1] The B group were analyzed for actual school achievement (in grade terms) and for the most apparent reason for leaving school. The table that follows summarizes our findings with regard to these 100 cases, showing for each the intelligence quotient, the chronological age, and the school achievement at time of leaving school. Where more than one psychometric examination was given, the average of the intelligence quotients is the one used. Cases are numbered for convenience of discussion in the text. Those marked by an asterisk will receive special mention. (G) and (B) designate girl and boy.

Before proceeding, I suppose one should take precautions against any reader's assuming that we hold the I.Q. a literally exact representation of intellectual capacity (for school attainment). Drawing a line at I.Q. 90 and saying that all above that line can do high-school work and all below cannot

[1] See Terman table, page 323.

is somewhat arbitrary and must not be interpreted too literally. Mental ability does not define itself so sharply. An I.Q. a point or two above or below 90 is more or less equivalent to 90; several points of difference, of course, tend to take on the character of a distinctly higher or lower quotient. For the sake of clear-cut analysis, such exact classifications serve a purpose, though in actual practice they must be used with common sense.

INTELLIGENCE QUOTIENT (STANFORD-BINET), CHRONOLOGICAL AGE, AND SCHOOL ACHIEVEMENT OF 100 DEPENDENT CHILDREN NOW AGED 16 YEARS OR OVER

A. CASES CONSIDERED TO HAVE HIGH-SCHOOL ABILITY (I.Q. 90 OR OVER).

I. *Graduated from high school* **

	I.Q.	*Chronological age*	*School achievement*
*1. (G)	119	16 years, 5 months	Classical course
*2. (B)	115	18 years, 3 months	Technical course
3. (G)	115	16 years, 2 months	Classical course
4. (G)	113	16 years, 4 months	
5. (G)	104	17 years, 4 months	Technical course
6. (G)	101	17 years, 9 months	Classical course
7. (G)	99	18 years	
8. (G)	99	18 years, 5 months	Classical course
*9. (G)	99	17 years	Classical course
10. (G)	97	18 years, 11 months	
*11. (G)	97	19 years, 3 months	
12. (G)	96	18 years, 3 months	
13. (G)	96	18 years, 2 months	
*14. (B)	96	18 years, 8 months	
15. (G)	95	17 years	Scientific course
16. (G)	91	18 years, 9 months	Technical course
17. (G)	90	19 years, 9 months	

II. *Not graduated from high school (with explanation).*

a. Withdrawal due to poor school work (advised to leave).

*18. (B)	121	15 years, 2 months	Failed 1st high school (classical) 3d trial.
*19. (B)	102	16 years	Failed 1st high school, 2d trial.
*20. (B)	102	16 years, 11 months	Failed 2d high school
*21. (G)	100	16 years, 8 months	Failed 2d high school
*22. (B)	100	17 years	Failed 2d high school (classical).
*23. (G)	100	18 years	Failed 4th high school
*24. (B)	99	17 years, 5 months	Failed 2d high school
*25. (G)	91	15 years, 6 months	Failed 1st high school

** High-school course, where not otherwise designated, is commercial or vocational.

b. Withdrawal due to other causes.

Preferred trade school.

	I.Q.	*Chronological age*	*School achievement*
*26. (B)	97	18 years, 3 months	Graduated trade school

Preferred to go to work.

*27. (G)	109	16 years	Completed 1st high school (classical).
*28. (G)	97	16 years	Completed 8th grade
*29. (B)	95	17 years, 8 months	Completed 3d high school.
*30. (B)	95	16 years, 10 months	Completed 3d high school, 2d trial.

Removed by parents to go to work (against advice).

*31. (G)	103	14 years, 7 months	Two months of 1st high school.
*32. (G)	114	15 years	Completed 1st high school (classical), 2d trial.
33. (G)	104	14 years	Two months of 1st high school.
34. (B)	95	18 years	Completed 1st high school.
35. (B)	94	15 years, 9 months	Three months of 1st high school.
36. (G)	94	18 years, 6 months	Two months of 1st high school.
37. (B)	91	17 years, 11 months	Two months of 4th high school.
*38. (B)	90	16 years, 8 months	Completed 8th grade. (Retarded by eye trouble.)

Ran away.

*39. (G)	100	15 years, 9 months	Completed 8th grade. (Psychopathic.)
*40. (G)	91	18 years, 9 months	Completed 2d high school.

III. *Still in school* (*June 1925*).

41. (B)	112	16 years, 7 months	Completed 1st high school.
*42. (B)	107	16 years, 5 months	Failing 1st high school. Trade school.
*43. (B)	106	16 years, 3 months	Completed 1st high school.
44. (B)	98	16 years, 9 months	Completed 2d high school.
*45. (B)	100	18 years, 4 months	Completed 2d high school, 2d trial.
*46. (G)	96	16 years, 10 months	Completed 3d high school.
*47. (B)	93	16 years, 8 months	Failed 1st high school.
48. (B)	93	16 years, 5 months	Completed 2d high school.
*49. (G)	90	16 years, 10 months	Failed 3d high school.

B. CASES CONSIDERED TO HAVE LESS THAN HIGH-SCHOOL ABILITY (I.Q. UNDER 90).

I. *Graduated from high school.*

	I.Q.	*Chronological age*	*School achievement*
50. (G)	83	19 years, 4 months	
*51. (G)	83	18 years	
*52. (G)	80	18 years	
*53. (G)	80	20 years, 5 months	

II. *Not graduated from high school.*

a. Graduated from trade school.

*54. (B)	76	19 years, 5 months	

b. Removed by parents to go to work.

*55. (B)	89	16 years, 7 months	Completed 8th grade.
*56. (B)	88	13 years	Completed 7th grade.
*57. (G)	80	15 years, 10 months	Completed 1st high school.
*58. (G)	79	14 years	Completed 5th grade, 2d trial.
*59. (G)	78	15 years	Completed 8th grade.
*60. (G)	75	15 years	Half through 6th grade.

c. Advised to leave for work or trade school (can't learn more).

61. (B)	87	16 years, 10 months	Completed 8th grade.
62. (B)	87	17 years, 10 months	Failed 1st high school.
*63. (G)	86	17 years, 11 months	Third high school, 2d trial.
*64. (B)	85	17 years, 7 months	Failed 2d high school.
65. (G)	85	15 years	Completed 8th grade.
*66. (B)	85	17 years, 7 months	Failed 2d high school.
67. (B)	85	14 years, 3 months	Failed 1st high school.
*68. (G)	85	18 years, 2 months	Failed 4th high school.
69. (B)	85	14 years	Failed 7th grade.
70. (G)	84	14 years	Completed 7th grade.
71. (G)	79	15 years, 3 months	Failed 7th grade, 2d trial.
72. (B)	81	16 years	Failed 1st high school.
73. (G)	80	16 years, 9 months	First high school (Jr. high-school honor).
74. (B)	80	16 years, 9 months	Completed 8th grade.
75. (G)	80	16 years, 7 months	Completed 8th grade.
76. (G)	80	15 years, 2 months	Failed 1st high school.
77. (G)	84	17 years, 8 months	Failed 1st high school.
78. (B)	80	15 years	Completed 8th grade.
79. (G)	80	15 years	Failed 8th grade.
80. (G)	78	17 years, 3 months	Failed 8th grade.
81. (G)	78	15 years	Failed 7th grade.
*82. (B)	78	16 years	Failed 4th grade.
83. (G)	75	13 years, 8 months	Completed 8th grade. Graduation refused.
*84. (G)	75	18 years, 1 month	Failed 3d high school.
85. (B)	72	15 years, 4 months	Completed 6th grade.
86. (B)	70	15 years, 10 months	Failed 7th grade.

	I.Q.	*Chronological age*	*School achievement*
*87. (B)	70	15 years, 2 months	Failed 1st high school.
88. (B)	63	15 years	Failed 5th grade.
89. (G)	61	16 years, 8 months	Completed 6th grade, 2d trial.
90. (B)	59	17 years, 4 months	Failed 7th grade, 2d trial.
d. Delinquent.			
*91. (G)	84	15 years	Eighth grade.
*92. (G)	71	18 years, 11 months	Failing 2d high school (C and F marks).
e. Psychopathic.			
*93. (B)	88	16 years	Failed 1st high school.
III. *Still in school (June 1925).*			
*94. (B)	89	18 years, 7 months	Completed 3d high school.
95. (G)	89	16 years, 2 months	Graduated grammar school; now in trade school.
96. (G)	82	15 years, 10 months	Completed 1st high school (C marks).
97. (G)	81	16 years, 8 months	Failing 1st high school. Trade school advised.
98. (G)	78	16 years	Failed 8th grade; now in trade school.
99. (B)	71	16 years, 7 months	Pre-vocational, ungraded. (Failed 5th grade at 14 years, 7 months. Hearing defect).
100. (G)	69	16 years, 9 months	Failing 7th grade. (Cardiac case).

For purposes of comparison and comment on these findings, the final mental age and the school-grade expectancy for the various I.Q.'s is quoted from Terman.[1] (I have taken the liberty of tabulating from the text.)

I.Q.	*Final mental age*	*Final school age*
60	9–10	Third or 4th at about 16 years.
70	11	Fifth or 6th by much repetition at about 16 years.
80	12½	Seventh. (May reach 8th or even 1st or 2d H. S. if in school long enough and promoted mechanically and sympathetically. Never able to do average high school with any degree of satisfaction.)
90	15	Eighth. (May graduate from high school if persistent.)

[1] *The Intelligence of School Children*, p. 129.

"In all probability the large majority of college students would in the grammar school have tested 100–130, with the median perhaps 115–120. Chances are remote that a child testing much below 90 will ever be able to satisfy the requirements for college graduation. Children who test below 100 should ordinarily not be encouraged to look forward to entrance to law, medicine, the ministry, engineering, teaching, or any other profession which demands a high degree of ability in abstract or conceptional thinking. Substantial success in such professions is probably achieved only by individuals above the 115 or 120 class."[1]

To facilitate our analysis of school achievements, it may be well to call to mind the age-grade progression as commonly used in the public schools. On the supposition that the child enters the first grade at six and advances one grade each year, he should enter Grade 2 at seven, Grade 3 at eight, and so forth, entering high school at fourteen and completing about eighteen. Needless to say, this program must be interpreted approximately rather than exactly, since few children enter first grade on their sixth birthday.

On examination of Group A, we find that the I.Q.'s of the seventeen who completed high school are, in all but two cases, noticeably above 90, varying from 95 to 119. The fifteen with I.Q.'s of 95 or over, all except one (I.Q. 97), completed high school before the nineteenth year. The three who completed high school before the seventeenth year were of superior intelligence, with I.Q.'s of 113 or over. The only case of superior intelligence who took the usual time for high school is one of the two boys who break our otherwise solid record of graduating girls only, in the period of seven years. For him (Case No. 2) the very highest advantages were secured, but he lacked industry, interest, and ambition to study. Owing to his good native intelligence, he could not help graduating. He had expressed a mild desire for advanced technical education. The test indicated fitness, but he failed to pass the entrance examinations to the Massachusetts Institute of Technology. He was then urged into a liberal-arts college, failed in his second year, and was asked to leave, chiefly because his "Bolshevik" attitude had a bad

[1] *The Intelligence of School Children*, p. 282.

influence on other boys. He is now at work as a salesman and is making considerable success. This boy was a puzzle; nothing seemed to "get under his skin". He accepted everything offered and even demanded more, but made no effort to show appreciation or to make returns even by little courtesies in the foster home. Owing to his excellent intelligence rating and fine physical appearance, he was given favors and opportunities that no other child in our group had, indeed that few children of any social status have even in their own homes. He had, to be sure, an unfavorable heredity. His father, at one time an expert workman, became alcoholic, deserted his family, and disappeared; his mother, a fine woman, died of tuberculosis; one sister, a capable girl of splendid character, developed epilepsy in the early twenties; and another sister (Case No. 28) has been a persistent psychopathic sex delinquent. Early spoiling probably helps to explain this boy's poor showing. If more had been expected of him earlier, he might have responded. He is making his best record now that he is working for himself. Possibly the effort and the money expended on this boy will yet bear results.

The only other boy we have been able to "pull through" high school in the seven years is of quite another type (Case No. 14). His ambition and persistence in school have been unflagging. He worked in stores all through his high-school course, earning spending money and clothes. He appears a "sissy boy", and except for one runaway in the early grades, has given little or no trouble. He comes of very poor stock and social background, a fact difficult to reconcile with his social and financial ambition. He fixed his goal at the U. S. Naval Academy, but by tactful handling, was influenced to shift it to becoming manager of a five-and-ten-cent store, an ambition he seems in a fair way to realize, since he is already an assistant manager.

Of the fifteen girls who graduated from high school, much might be said. Many of them earned their board all through the high-school course. All dealt successfully with the painful emotional conflict that inevitably accompanies family breakdown and dependency. One was an illegitimate child, and only two had anything like a normal interest from a mother

or a father. They make a fine showing of achievement under difficulty. All but one have had, since completing high school, some advanced schooling. Five are now fitting themselves for teaching, one graduated from a state normal school at twenty, three hold responsible clerical positions, one is a textile designer, one graduated from Sargent School and is now a physical-education teacher, one was graduated from a nurses' training school of high standard, one is still in training, one is taking advanced musical training, and one is married.

Those in Group A who did not graduate from high school fall into two classes—those who actually failed and were asked to leave because of poor scholarship, and those who did not fail in scholarship, but were removed for the reasons noted. It will be seen that eight, out of a total of forty whose I.Q's afforded an expectation of high school, failed because of inability to do the work and fifteen failed for other reasons. It is a curious fact that among the eight who failed because of poor scholarship the highest I.Q. is well above any of those who graduated, and the average I.Q. of those who failed is 102 while the average of those who graduated is 95.

Two (Cases No. 23 and No. 24) of the eight who seemingly failed because of poor scholarship may actually be accounted for on the ground of incipient psychotic symptoms not recognized as such until after they had left school. Subsequently both were patients in state hospitals for the insane and diagnosed dementia precox. One of them is still in the hospital, the other remained two or three years and then was discharged as improved. She married after leaving our care at the age of twenty-one and disappeared. One of the high-school failures has the highest I.Q. of any in the study (Case No. 18). He failed the first year of Latin school on third trial at fifteen years, and was then refused another trial. His father was dead and his mother "pampered him", but his heredity, as far as we know, is much better than the average of the children in our study. He had entered high school at thirteen, but with his I.Q. (a mental age of approximately 16 years) it should not have been too early. He had no interest in school and would not study. His failure is probably explainable on the ground of lack of intellectual taste.

In the case of another boy (Case No. 20) with an I.Q. of

102 the failure is due probably to his having been pushed too rapidly. An adopted child, a foundling, and delinquent, he went from school and our care to his adopted parents and now works in a shoe factory. Case No. 21 (I.Q. 100), an attractive, mature-appearing girl, also had been advanced too rapidly for her ability. She was unhappy in foster homes. Unable to stimulate her to bring up her school work, we allowed her to leave second year high school at sixteen years, eight months, to enroll in a school for nursery maids, as a first step towards hospital training, for which she showed a desire and fitness. Cases No. 19 (I.Q. 102) and No. 22 (I.Q. 100) were lazy and indifferent to school; one was easy-going, the other grouchy and antagonistic. Case No. 19 seems steadily deteriorating since leaving school, is careless and dirty in appearance, unable to keep a job more than a few weeks, and suggests an incipient psychosis. Case No. 22, after failure in school, was sent to his father, a contractor in the Middle West, who easily secured him a job at $4 a day. He has recently had a serious illness and a surgical operation. His overheavy body, general sluggishness, ravenous appetite, and other symptoms, suggested a glandular disturbance, but his school failure seemed related rather to "bad attitude" than to physical defect—perhaps they belonged to the same picture. His mother was insane, but his father a capable person. One brother (I.Q. 128) is still in school in our care; he shows excellent scholarship, but is too young to include in this study. Case No. 24 has a brother (Case No. 30), who left school because he preferred to, and a sister (Case No. 31), who was taken out of school against our advice. His failure is due probably to change of school and course, at the end of his first year, from a suburban to a stiff-standard city high school, but he also had a bad attitude—was unpopular with his mates and teachers, pronounced "yellow" and dishonest. He is now doing fairly well in a bank.

From the standpoint of the agency, at least, this group is probably the most baffling and significant of the study because of the time, money, and effort expended without visible result. In each case, the visitor labored unceasingly to clear up the school difficulty, as every visitor will, to keep a "bright child" in school. In certain cases tutoring was

secured, in others foster homes were changed, in two cases psychoanalysis was tried. In going back over the history of these cases, I cannot see that any remedial measure known to social case-work was omitted. Undoubtedly the roots of the maladjustment went back into early childhood. That it had any particular relation to heredity, I should be unwilling to say in view of the fact that the heredity of those who succeeded in school was equally poor. These cases emphasize the fact that a high I.Q. is not the only factor in school success. There must be also positive personality traits and favorable attitudes to back it up.

Of the fifteen whose failure to complete high school was due to causes other than inability to accomplish the work, little explanation is needed in addition to that already noted in the table. Strictly interpreted, they should not be regarded as high-school failures. Case No. 26, a boy with an I.Q. of 97, could easily have graduated from high school, but after two years he preferred a training in the sheet-metal trade. He is steady and industrious, without social graces or ambition, but of high character. His heredity is extremely poor. Case No. 54 (I.Q. 76) is his twin brother and Case. No. 9 (I.Q. 99), his sister.

The four cases who refused to continue, preferring to go to work, explain themselves. They became so dissatisfied with school and so anxious to be self-supporting that it was useless to try to keep them in school, although we made every effort to do so, since their scholarship warranted it. All but one (Case No. 28) are doing as well at the moment, apparently, as if they had completed high school. Case No. 28 has been a decided sex problem, before and after a hasty marriage which took place during the progress of an illegitimate pregnancy. She contracted syphilis and now has a child two years old, decidedly retarded in mental and physical development. She is a sister of Case No. 2, the boy who made so poor a record for his superior I.Q. and superior advantages. Case No. 30 (I.Q. 95) completed second year in commercial high school at fourteen years, ten months, was changed to a stiff-standard school for his third year, failed to pass, repeated, and completed third year high school at sixteen years, ten months. He ran away to Chicago during the sum-

mer vacation and got a job carrying trays in a Y. M. C. A. cafeteria, but was persuaded to return to us. On his own request, he was allowed to take a position while continuing his fourth-year-high-school work in evening school. He soon tired of this, ran away again, and joined the army aviation corps, where he is at the present time. This boy was active in athletics, socially popular, and a typical "Seventeen" of Booth Tarkington. His failure to complete high school is due partly to a too rapid school advancement (note mental age) and partly to a change from a high school to which he was devoted and in which he was quite an important figure to one in which he was a stranger to teachers and pupils and had to make entirely new contacts. The question of changing schools will be touched on later. Cases No. 27 and No. 29 were unhappy, troublesome, and restless and both ran away at least once while in school, but now hold good positions and are well adjusted. The school failure of both seems due to neurotic adolescent traits, linked with an active dependency complex.

The eight who were taken out of school by parents against advice also need little explanation. They were not failing in high school. In every case the child desired to continue, but was denied by parent or guardian. In these cases guardianship was not in the hands of our agency, except in Case No. 32, a girl with an I.Q. of 114, who desired to go to live with an aunt whom she had finally persuaded to take her. This we allowed on the understanding that the high-school course be completed. Soon, however, family difficulties made it necessary for the aunt to take her out of school to work. The same difficulties, connected with the husband of the aunt, made it necessary to bring the girl back to our own care. She had then lost so much time that it was thought unwise to return her to school. She is now a salesgirl in a high-class store and has had several promotions, but whether she will ultimately progress as far as she might with a high-school education is of course a question. The fact that Case No. 38 (I.Q. 90) had reached only the eighth grade at sixteen years, eight months, is explained by much loss of school as a result of eye trouble.

The two who ran away cannot be classed as actual high-

school failures. These are two sisters, Cases No. 39 and No. 40—I.Q. 100 and 91 respectively. One, a psychopathic personality, had given us an immense amount of trouble. Spells of violent temper, stubbornness, and waywardness made it necessary to change her home every few months, and consequently her school. These breaks interfered with her school interest, always fitful at best. She developed precocious and morbid sex interests, which further affected her school work. Adolescence well under way, she seemed to be doing much better, when suddenly, during the summer vacation (1924), she ran away in company with her older and quite stable sister, who happened to be paying her a visit. They were missing several months, tried their hand at desultory work under assumed names, and seem to have lived near to the edge of reputability. When finally located through the police in a neighboring city and returned to us, it was evidently useless to attempt further formal schooling. Placed at their own request in the rather poor home of a relative, they found jobs for themselves in a factory at $12 a week. These girls had always been difficult because of disagreeable and changeable dispositions. The more stable one had been self-seeking and shrewd, and school had appealed to her as the best thing she could get from us, but she lost her head under the erratic dominance of her sister and the idea of "freedom from the agency". These girls came to us as tiny tots when their mother died, from a very poor home and background. They never really accepted our social and moral standards, though we tried them in many different types of homes and strove earnestly to understand and supply their needs. We consider these cases perhaps our worst failures.

The cases with I.Q.'s of 90 or over who are still in school at sixteen require little comment. From present indications, six of the nine will undoubtedly fulfill their I.Q. expectations and complete high school; three (Cases Nos. 42, 47, 49) will quite surely not, because of neurotic, unstable natures which seem unable to endure the steady application and the irksome routine of the classroom.

To pass on to Group B—cases considered of less than high-school ability (I.Q.'s below 90)—four of the fifty-one in this group actually graduated from high school. The fact that

these children with I.Q.'s of 80 to 83 were able to complete the high-school course tends of course to challenge the dependability of our predictions. But we cannot overlook the fact that one of these cases required one year and another two years more than the usual time, although the other two were still in the eighteenth year at graduation. All of these girls took commercial courses. All were reported as "slow in grasping ideas" and got through on barely passing marks. We may question the validity of the I.Q. in Case No. 51, a psychopathic girl of illegitimate parentage, though tests by different examiners five years apart varied only five points. She later became delinquent and committed suicide on second attempt. Case No. 53 was tested only once, and though no errors have been detected, the I.Q., for some undiscovered reason, does not seem to represent her ability. She now is making a good record in a nurses' training school. The other two had to have much extra help. Case No. 52, while in high school, had a strong ambition for a college course. Later she was refused admission to a school of physical training because her high-school marks had been so low. She took a course in filing, and under wise supervision, has been able to earn enough to support herself. These four girls had excellent personalities, were steady, ambitious, patient, and much liked by teachers. Their heredity, too, with one exception, was somewhat above the average of the others in this study. Quite surely, teachers, more or less unconsciously, give much credit for fine traits of character and pleasing personality. Intelligence alone, as has already been pointed out, unless exceptionally good, seems hardly sufficient to carry a pupil through high school, and, conversely, unless strikingly poor, does not always prevent his getting through. The I.Q. plus or minus certain non-intellectual attributes is what has to be reckoned with.

Of the total now out of school (44) whose I.Q.'s offered no reasonable expectation of high-school achievement, in addition to the four who actually graduated, fifteen were in high school before receiving the official label of failure—one in the fourth, two in the third, three in the second, and nine in the first years. All of them had I.Q.'s from 80 to 83, except two, whose I.Q.'s were 70 and 75 respectively.

Case No. 54 illustrates the satisfactory handling of the school training of a boy with an I.Q. of 76 which might well serve as a model for pupils of similar intellectual equipment. He completed grammar school at fifteen years, four months. We then placed him in an agricultural school where the principal thought him a promising subject. He preferred to follow in the footsteps of his brother (Case No. 26) and learn the sheet-metal trade. Although he had rather poor manual ability, he was ambitious and industrious and finally graduated at nineteen years, three months. He works now alternately at his trade and at farming.

Six children of the B group were removed from school and placed at work by parents. In these cases our agency was saved the necessity of decision by the interference of a parent. I doubt if we would have had the courage in all instances to remove the children from school so summarily, even though intelligence tests and school records of failure clearly indicated that their academic limit had been reached. We have become so habituated to the idea that going to school is the only thing young people can do that it is almost impossible to recognize the point at which they have had enough. Unquestionably every one of this group could have profited by practical trade or vocational courses, but none were available. Case No. 55 (I.Q. 89) left school to take employment in a printing office, where he received a fine training. Case No. 57 (I.Q. 80) went into a telephone operators' training school at $12 a week. Case No. 59 (I.Q. 78) went to work in a curtain factory. Cases No. 58 and No. 60 went into domestic work. Case No. 56 tried various jobs, then ran away, and has not since been heard from.

Thirty children were advised to leave because of inability to do further school work, fourteen being in high school. Two (No. 91 and No. 92) ended their school careers ostensibly because of misconduct, and one (No. 93) because of psychopathic instability. Although the three last mentioned had not been formally notified, they had actually reached the point of saturation with school work. Whether retaining them in school had a beneficial effect may be gathered from the brief account to follow. Case No. 68 (I.Q. 85) reached the fourth year of high school, commercial course, but was

refused graduation because of insufficient credits, having failed in stenography entirely and received "just passing marks" in other subjects. She was then only eighteen years, two months old and had changed schools several times, a remarkably good record in view of her equipment. Although she failed to graduate, she unquestionably gained much from her experience in high school and in her foster homes. She went home to keep house for her father and brothers, a duty that she continues to carry on with considerable success.

Case No. 63 (I.Q. 86) failed third year high school on second trial at the age of seventeen years, eleven months. She is now taking a course in a business school and making a fair record. Cases No. 64 and No. 66, each with an I.Q. of 85, reached second year high school and failed. Both went to work, one in a factory and the other in housework. One has since married satisfactorily. Case No. 91 left school in the eighth grade because she was pregnant. Most astonishing are the three with I.Q.'s of 70, 71, and 75, respectively, who were advanced to first, second, and third year high school. Case No. 92, a girl with an I.Q. of 71, of illegitimate parentage and extremely bad heredity, was rated by three different schools "very slow, D. and F. marks" in commercial course. To have subjected this girl to the competition of high school was unjust. We should have known better if the schools did not. Small wonder she "ran away" in the second year of high school at the age of eighteen years, eleven months, and went out to seek something more to her taste in New York. A simple, docile, pretty girl, she had no more sense than to fall in with a nice woman on the train, who, on arrival, directed her to the Travelers' Aid. In this way, she came back to us—but not to school. When last heard of, she was under supervision by another agency and working as ward maid in a hospital.

Case No. 87 (I.Q. 70), a boy, when told that he must leave first year high school, to which he had been promoted on trial, flew into a rage at the principal, vowed to blow up the school, and continued to write anonymous, threatening letters. He refused our belated offer of trade school and went to work passing rivets at a government shipyard at $24 a week (war time). When last heard of, he was an errand boy. His

excellent manual ability was shown by tests and in practical ways. He should have been given vocational training instead of being allowed to be overwhelmed in high school. This case calls to mind a similar case of a girl with an I.Q. of 70 (known from a neighbor agency) whose aspiration was to become a teacher. When informed in her first year of high school that the work was beyond her, her mother employed a lawyer to sue the school authorities for discriminating against her child. Case No. 84, a girl with an I.Q. of 75, while yet a small child in the grades, was predestined by an ambitious foster mother to become a kindergarten teacher. When she began to fail in school work and to show delinquent tendencies, the foster mother asked us to remove her from the home. Still aspiring, she worried on into third year high school and was asked to leave (aged eighteen years, one month) because unable to do the work. Her ambition persisted, and aided by a good physical appearance and a refined manner, she gained admission to a nurses' training school, but did not survive her probation period and was asked to leave. Various jobs followed and then she married.

Case No. 93 has been labeled psychopathic. Handsome in appearance, charming in manner, he makes an excellent first impression, but is so erratic and impulsive that his conduct is entirely unpredictable. He failed first year high school at sixteen, and two or three subsequent attempts at school work ended after a few weeks. With jobs it is the same story. Through stores, steamships, offices, farms, and so forth, he flits lightly. He satisfies his employers, but they do not satisfy him. He runs away and turns up again. He has been in court on serious charges, but has always been released on probation because for one reason or another the charges fall through. His home situation is most distressing. He cannot live in it and he cannot live away from it. He is kept in perpetual emotional tumult. Under these circumstances, the wonder is that he fulfilled even the minimum I.Q. prediction.

Of the remaining cases of less than high-school ability, those who did not advance as far as high school, a glance at the prediction table will show how nearly they fulfilled the expectation of school achievement. All except one seem to have done as well or considerably better than expectation.

This favorable record undoubtedly is due to the school tendency of promoting mechanically on chronological-age rather than mental-age standards. Teachers who "keep back" many pupils are apt to be frowned on. The Massachusetts law requires that pupils must be fourteen years old and have reached the sixth grade before leaving school. It is natural, therefore, that dull pupils, except in extreme cases, should move on for a while with the stream, regardless of merit. The one case that did not fulfil the I.Q. expectation is a boy (Case No. 82) with an I.Q. of 78, who had reached only the fourth grade at sixteen, when according to expectation he should have reached the fifth or the sixth at least. One test only was given him, and it probably overrates his ability. He had been in atypical classes in public school and in a state school for feebleminded persons before he came to our care. His general appearance and ability seemed to indicate an I.Q. of less than 78. He now, at nineteen years of age, works at cleaning locomotives, earning from $18 to $25 a week, is dirty, shiftless, lacks common sense, and requires much looking after by a patient foster mother. With four exceptions, the thirty-three who left school because they were advised to or because they were delinquent or psychopathic were fifteen years or older when they left. All had reached the sixth grade at least except two—the boy just mentioned and a colored girl with an I.Q. of 78 who was repeating fifth grade at fifteen when her father took her out of school to go to work.

Of the seven with I.Q.'s of less than 90 who still remain in school at sixteen, it may be said with certainty that only one has reasonable expectation of completing high school. This boy (Case No. 94) with an I.Q. of 89, has completed the third year of high school at eighteen years, seven months. Although his marks are low, he has a fine, manly spirit, has earned his board and more all through his high-school course, and is esteemed in school and neighborhood. It would have been equally fair to have classified him in Group A. It is interesting to note that at one time this boy and a younger brother (Case No. 43) were much disgruntled with our care, indifferent to school, and antagonistic to their foster home. The presentation of bicycles by an understanding visitor, along with sympathetic attention to their complaints, "com-

pletely made them over", as the foster mother expressed it. The other six of this group show no likelihood of accomplishing high-school work. Two of them have decided physical handicaps; one is being given special vocational training and the other is being sent to the care of an aunt in California.

The outstanding inferences to be drawn from this study fall into two main divisions: the theoretical, which have to do with the validity of the intelligence tests as a basis for the prediction of school attainment; and the practical, which are concerned with the school problems that arise in the handling of children by such an agency as the Church Home Society. To take up the theoretical considerations first, the Binet tests in all their forms have been criticized as tests of natural ability on the ground that their success depends on school experience or on those qualities which insure success in school, but which may not be essential to success in everyday life. If this criticism is just, then these very tests should be all the more valuable for such purposes as ours. The fact that the mental age can be matched to grades is of great assistance when it comes to estimating the correctness of grading and to checking up school progress. It is as important to know when too much is being expected of a pupil as when too little. If a plan for education based on the intelligence quotient is to be made in the early years, it is obviously imperative that the I.Q. should be a reasonably fixed index.

The question of the constancy of the I.Q. on retest seems to have been already sufficiently settled to warrant its acceptance as a reliable guide. "The repetition of psychological tests at various intervals has shown that the I.Q. does not fluctuate sufficiently to demand frequent retesting."[1] Statistical tables on page 103 in the book from which this is quoted show the variation of the I.Q. on retest for 435 comparisons by Terman and 322 by Irwin and Marks, the former giving a correlation of .933 and the latter .98. The correlation between the first and last tests in our study is .92. In view of the long intervals between tests in many of our cases—from one to over five years—the wide range of ages represented, and the large

[1] *Fitting the School to the Child*, by Elizabeth A. Irwin and Louis A. Marks. New York: The Macmillan Company, 1924. Pp. 98, 103.

number of neurotic subjects, this correlation offers a striking confirmation of the constancy of the I.Q. Fifty-four of our cases were tested two or more times—a number not great enough to carry much weight, but since they add a bit of positive evidence to that already accumulated, they seem of sufficient interest to be mentioned.

Six cases only showed a variation as high as from ten to thirteen points. Two of these showed a loss of ten points, one, a boy (Case No. 19), already referred to as now showing signs of general deterioration suggestive of an incipient psychosis. The loss of ten points in his case may be only a part of the picture. The other (Case No. 1), a capable, dependable colored girl who completed classical high school at sixteen years, five months, is now preparing to be a teacher. A drop of ten points in two years and ten months is not in accord with the other factors in her history and is difficult to understand. Among those whose I.Q.'s improved noticeably is Case No. 46, a girl whose I.Q. went up from 94 to 107 in five years, six months. Whether this gain is the result of the effort of an advanced and ambitious foster mother to make a record and disprove our original prediction that the girl had not ability to go through college, one can only question. She admitted "a little drilling" before the last test. Another girl (Case No. 11) gained twelve points in two years, six months, a fine, steady, capable girl who earned her board and more all through her high-school course and is now in a training school for nurses. Two boys (Cases No. 45 and No. 54) each gained ten points; both seemed to "brighten up" mentally after improved physical and foster-home conditions.

Aside from the six cases just cited, the difference between the I.Q.'s of the first test and that of the last is negligible. Two cases show a variation in I.Q. of twelve points between the first and the second tests, but later tests reduced this difference to less than ten points. The fluctuation in these cases may be explained by the fact that one of the girls (Case No. 49) is neurotic and variable in everything she does. The other (Case No. 60) was examined first at eleven years old immediately after a long journey from her home, from which she had been legally removed as an unfit place. Malnutrition

and disturbed emotion appear to have affected her first test, a source of error not often encountered, though often expected.

As to the I.Q. as a basis of prediction of school achievement, we find that those children who had an I.Q. of 90 or over in the main *did not fail* in high school. Thirty-two of the forty have actually demonstrated ability to accomplish high-school work, while eight have not. Six of the nine still in school have potentially demonstrated ability to accomplish high-school work, while three have just been marked "failure". If we should eliminate, as really seems fair, the two whose failure was related to the onset of mental disease and the three who are now failing because of neurotic make-up and misbehavior, the negative evidence is somewhat reduced. But in order to take no favors from statistics, we prefer to lean towards the side of understatement, and therefore content ourselves with giving the strict minimum or 80 per cent who give positive evidence that an I.Q. of 90 or above really indicates ability to do high-school work. Those children who had an I.Q. of less than 90 in the main *did fail* to accomplish high school. Only four of the forty-four who have completed their schooling have actually demonstrated ability to accomplish the work, while only one of the seven still in school has any chance of completing. The latter (Case No. 90), with an I.Q. of 89, might, if we had stretched a point, have been included in the high-school-expectation group. Except for these five, the remaining 46 of Group B either failed to get into high school or to maintain themselves if they did get there. We have, therefore, 90 per cent who give positive evidence that an I.Q. of less than 90 will not accomplish high-school work. It seems fair to conclude that the Stanford-Binet tests are a very good, but not perfect basis for the prediction of success or failure in high school.

As to the more detailed prediction of the actual grade likely to be achieved for I.Q.'s less than 90, our study does not provide a sufficient number of cases to warrant conclusions. Furthermore, the factors other than scholarship that are known to influence grade promotion make evaluation of the actual school achievement on the basis of the grade reached slightly uncertain, particularly in such a wide sampling of schools as is shown in this study. Yet they have a certain

interest in that they tend to strengthen the positive evidence already accumulated as to the reliability of predicting school achievement from the intelligence quotient, and so the figures are given:

Outcome of the school prediction for I.Q.'s of less than 90 (51 *cases*)

I.Q. 89=80—prediction seventh grade (eighth grade to second high school if given time enough and promoted without actually warranting it).

Fulfilled	25
Bettered	6
Not fulfilled	1
	32

I.Q. 79=70—prediction fifth or sixth grade.

Fulfilled	5
Bettered	8
Not fulfilled	2
	15

I.Q. 69=60—prediction third or fourth grade.

Fulfilled	1
Bettered	3
Not fulfilled	0
	4

By far the strongest tendency in this group is to fulfill or slightly better the prediction.

With regard to the more practical aspects of the school problem, various inferences have already suggested themselves here and there through the course of this study—the chief, that it is well worth while for agencies to make use of intelligence tests—the Stanford-Binet or others comparable to it—as a basis for planning the school training of the children who are under their care.

From the mass of data that comes to the fore on intimate acquaintance with the 100 children in this study, it has been difficult to single out the thread of their school stories and evaluate accurately the cause of their success or failure in school. Scarcely one in the entire group was free from painful emotions connected with his dependency, unfavorable childhood setting, and very poor inheritance, yet when all is weighed, the I.Q. undoubtedly stands out as the strongest determining factor in their school achievement, which strikingly resembles that of ordinary school children.

To the agency, the advantage of a planned, over a trial-and-failure, method of schooling should be self-evident. The result in financial saving alone can be readily reckoned. The per annum cost of a school-going child to this society is approximately $300. If he is able to earn his board in the foster home or something in an outside job, as many are during the later school years, the cost is reduced, of course, but even then there are spending money, clothing, medical care, and other items to be supplied by the society. Frequently, when the school work is found to be falling off under the probability that there is not time enough for study, it is necessary to restore a child from a "free home" to a boarding status. In one way or another the per capita cost mounts up on the average to the sum mentioned. For a concrete illustration of the financial waste in unplanned schooling, let us take the case (No. 84) of a girl with an I.Q. of 75 who remained in school until the third year of high school at eighteen years, one month. According to prediction, her upper academic limit was about the sixth grade at fifteen years. Her school career, therefore, seems to have been a waste of approximately three years and nine hundred dollars. A part at least of the money thus unprofitably spent would seem to have been better invested if it had been used to help a girl with I.Q. 100 who is overworking out of school hours to pay her way through a teachers' training school. The implication is not that adopting a plan in advance will keep money in the treasury, but that it will insure more effective spending.

Obviously the financial is not the leading consideration in our attempt to prepare dependent children for independent and satisfactory life. The aim first and always is to develop the individual to his best possibilities for citizenship. If three or four years of mere exposure to school, regardless of whether the child was learning or not, were found to contribute to the desired result, we should undoubtedly advocate letting him sit it out. But, as has already been hinted, such procedure tends to have a destructive rather than a constructive effect on character, initiative, and later success. The trial-and-failure method has little to recommend it in comparison with a definite plan. The practical advantage to the child of a planned school program is no less than to the agency. Setting

a goal that he may reasonably be expected to achieve and toward which he may gradually direct his hopes and his effort is fairer than allowing him to fumble on blindly toward some impractical and unattainable dream which he will presently have to give up. Concrete examples of the poor results of such shifting of objective could be given, but we must forbear quoting further from our case records and leave them to the reader's imagination.

Once the plan has been carefully formulated, it should be held to pretty tenaciously until the prediction has been fulfilled, unless a very definite reason is found for abandoning it. It must not be forgotten that it is as important to end with skilful management the formal schooling when the I.Q. predition has been fulfilled as to strive to continue it when it has not. Lingering on in school under a consciousness of failure tends to engender habits of idleness, inferiority feelings, grudges, and other harmful mental states. Probably the tendency in children's agencies is to err on the side of keeping children in school after they have ceased to profit rather than on that of ending the schooling prematurely.

To further the successful carrying out of the school plan, it is necessary to regard other factors besides the intelligence quotient:

1. The elimination of inopportune changes of foster home and school will have to be striven for even more persistently than now. Before placing a child in a foster home, the family should be impressed with the social importance of the duty it is undertaking and the serious consequences of "unhoming" a child after he is settled. One of our girls, now out of our care, has recently told me of the depression and loneliness she suffered for months after she had been removed from a home in which she had lived seven years. She hated the new home, the new school, the new neighborhood. Only an intelligent reasoning out of the situation and the fact that the new school was "easier" made it possible for her to continue her school work with credit. When re-location is unavoidable, the visitor should try to select the new home in a town where the school curriculum is similar to the one the child is leaving and to time the change so as to prevent unnecessary loss of grade. A change of school in the middle or toward the end of the

school year frequently brings a loss of the whole year's work even with bright pupils, because, in addition to the difference in the subject matter and its presentation in different schools, there is the upsetting of the child's emotions. To understand what this means, we have only to look back into our own early school days and imagine the probable effect on us of being uprooted from our homes and carried into new fields where we would have to forget old companions and make a place in an entirely new setting, let us say in the middle of the seventh grade or even the second year of high school. I am sure even the brightest of us would have "lost a grade". Many of our children had to change schools several times before they finished.

2. Another point to be stressed is the importance of keeping in personal touch with the school, to interest the teachers and principal in the child and secure sympathetic understanding of his problem, especially to prevent the indiscriminate and harmful dubbing of him as a "state child" and the embarrassing situations often occasioned by it. One of our small boys whose legal name had never been settled confessed to me with distressed confusion that the reason he hated school and ran away from it was that the teachers were continually asking his father's name. He had been told to give the name of his foster father. But when a stern teacher stood him up in front of his class and icily demanded, in the name of accuracy, to know how his name could be Jones and his father's name Greene, his little mind was not equal to expounding the involved question of guardianship. All he felt was that the eyes of the school turned on him, making fun of the "boy who didn't know his father's name", and naturally he tried to escape them by running away.

3. It is important also to understand the personality of the child and to clear up emotional conflicts. As an introductory step in the understanding of personal difficulties, I have found the test procedure of considerable assistance. It provides a natural and easy approach to the child's acquaintance and confidence, and in addition to affording information as to range of intelligence, it sometimes offers, to the experienced and observant examiner, substantial clews to the child's past experiences, mental attitudes, emotional repres-

sions, and other data needed in dealing fairly and wisely with the problems of childhood and youth so commonly encountered in a child-caring agency. Several of our children failed, apparently, because of psychopathic or neurotic constitutions. The dependent child who is also psychopathic has a stormy time in getting through school. These children require, needless to say, endless consideration and patient study. For them work of a suitable kind is often less of an irritant than the lock-step routine of school. But usually it is a never-ending procession of jobs that the visitor has to find, just as in the case of dull, untrained children. For although the psychopathic child often has ability which easily obtains him employment and though he begins with enthusiasm, he quickly tires of work, fails to turn up on time, takes a day off when he feels like it, and is soon dismissed. Just how much we can do to overcome or modify these psychopathic traits, I am not sure. Results are often disappointing, but occasionally a brilliant success stimulates to renewed effort. Certainly these cases are well worth struggling with as mental-hygiene problems.

In conclusion, the writer wishes to disclaim any intention of subscribing to the idea that the curriculum of the public schools, as now administered, is perfection. We have had numerous evidences of certain defects. At present the schools offer little for children in the lower ranges of intelligence after they have reached the age of twelve. There is great need for more trade schools, for courses in practical prevocational training associated with the regular grade instruction, for greater flexibility of grading—in short, for a general modernizing of the whole system. Changes of this sort are bound to come—indeed many of the improvements noted are already seen in many schools. If agencies such as ours, and others who deal with children, would exert their influence to hasten such improvements in the public schools, it would be of great help to superintendents of schools and boards, who always have to wait for public sentiment to back up any advance they wish to make. Meanwhile the child-helping agency will have to make use of the schools just as they are. That is why we have striven at such length to work out this argument for their more effective use.

And now we come to the question: Should agencies who care

for dependent children hold as high ideals for their education as the family holds for its own children? The answer is: Yes; but the ideal should never be a preconceived general one, but always an individual, concrete one, based on the intellectual endowment of each child as shown by psychometric tests. Except integrity of character and sound physical health, school training is the most valuable thing an agency can bestow on its children. The dependent child has not the social and financial backing that almost every ordinary child has in some degree when he starts out into the world. His possessions are literally his brain and his hands. Therefore, he needs to have these trained to the best that is in them if he is to compete successfully with his associates. By the very nature of the service, the child-helping agency will inevitably be overweighted with the less well-endowed children. Naturally it is much easier and in general more interesting to work with the brighter children, who, if trained, promise success as lawyers, engineers, artists, and so forth, and if untrained, promise at least moderate success in something. But—although it seems too obvious to need repeating—it is no less important to work with the duller children who, if trained, promise success as painters, clerks, farm helpers, waiters, and the like, and, untrained, promise success in nothing and are very likely to add to the ranks of idlers, wasters, and troublemakers.

With the diagnostic technique now at its disposal, the private agency, such as ours, could of course select only the higher-grade and more promising cases—those who offer a maximum of success with a minimum of effort. But what, after all, is success other than that each human being should feel the satisfaction of expressing the best that is in him? When all is considered, the highest social service for each agency would seem to consist in accepting, so far as it is able, the responsibility for all the needy children who come naturally to its door through church, neighborhood, or other community association, and then, once it has accepted the responsibility, standing by them with all the loyalty and devotion of the true family.

THE GENERAL PERSONALITY AND CERTAIN FEATURES OF THE SEX LIFE*

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WE owe to the genius of Hans Christian Andersen a prophetic vision in his story of the emperor's new clothes. It will be recalled how a journeyman tailor came to the court offering to make the sovereign a robe which, in addition to the utmost material splendor, should be visible only to those with an I.Q. above 105. Being amply furnished with silks, gold, and jewels, he wove them into an exquisite figment of the imagination which every one admired, not wishing to betray lack of discernment. On a day appointed, the monarch paraded in state down the esplanade amid the plaudits of the beholders, until the conventional small boy turned wonder into derision by exclaiming at the appearance of the imperial majesty in an undershirt. Examining the symbolism of his narrative from the point of view of psychoanalysis, it is clear that in the words of the distinguished French absolutist, *l'amour, c'est roi.* The robes he wears are the garment of convention, and very expensive fabrics they are, which only persons of refined sensibilities are able to value at their true worth. And in the small boy calling attention to the tenuity of these habits, we can scarce mistake the figure of Sigmund Freud, arch protagonist of those tendencies which have transformed the mysteries of yesterday into the cynosures of our own time.

Amid the hootings of the rabblement, the craning of necks and jostling of shoulders, it is difficult to obtain personally such detached view as is due to scientific observation; but with the support above mentioned, one may endeavor to climb,

* The study reported in this article is part of a series of investigations made possible by the Committee for Research on Sex Problems, Division of Medical Sciences, National Research Council. It is based on a paper read at the meeting of the American Psychological Association at Ithaca, New York, December, 1925.

Zaccheus-like, into the tree of collective experience, thence to regard the qualities and conditions of the imperial person with a more objective scrutiny. The material on which the present remarks are principally based is the second of two studies by my colleague, Dr. Peck, and myself, embodying the replies of over two hundred men graduate students to an inquiry designed primarily for comparison of the facts of the overt sex life with other features of the personality. A tabulation of the replies has been published,[1] and present concern is with interrelations.

Almost all this group, and probably educated persons in general, favor some systematic instruction of young people in sex matters, before they become wise enough to instruct their elders. Of the present group, 44 per cent record themselves as having had such instruction, and it is pertinent to examine the subsequent course of their sex lives to see if they differ in any way from the lives of the less instructed. It must be remembered that while we can judge of the effect of such instruction as was given, we must assume its conventional content.

No relation is shown between instruction and the frequency or duration of auto-erotic practice. Instruction is associated with somewhat fewer persons reporting heterosexual activity before marriage up to the ages here considered. It is recorded in 33 of the group, the proportional share being 37. On the other hand, a quite neutral relation appears between instruction and the numbers of such episodes, through a reported range to over 100 in three cases. The amount of activity reported is markedly less than the suppositions of smoking-room gossip. It falls well into line with observation reported by Kerns [2] on a West Point group.

The number with instruction who have dealt with but one woman is 4; the proportional share is between 7 and 8. The number without instruction who have dealt with but one woman is 13; the proportional share is 9. The number with

[1] *Further Studies in the Psychosexuality of College Graduate Men,* by M. W. Peck, M.D., and F. L. Wells. MENTAL HYGIENE, Vol. 9, pp. 502–520, July, 1925.

[2] *Management of Acute Mental Hygiene Problems Found Among College Men,* by Major Harry N. Kerns, Medical Corps, U. S. A. MENTAL HYGIENE, Vol. 9, July, 1925. P. 280.

instruction who have dealt with 5 or more women is 21, the proportional share being 17; the figures for those without instruction are 17 and 20 respectively. Instruction seems to go with a slight spread of the "libido". This should be taken in connection with the data on prostitutes. Fourteen of those with instruction record minimal contact with prostitutes; the proportional share is 21. Thirty-two of those without instruction have thus safeguarded themselves; the proportional share is 25. It is as if the instruction had turned its recipients somewhat in the direction of prostitutes—in accordance with a time-honored principle of sex ethics that while it is reprehensible to strike a person down, it is merely a venial misdemeanor to kick him when he is down.

The larger question is raised whether any particular sex life policies are associated with particular personality traits outside this sphere. As with regard to instruction, the general answer of the data is neutral. The relationship observed between the overt sex life and other personal traits is so complex as to look very like chance. It affords no basis for the formulation of a generally more or less desirable life policy from the standpoint of individual mental hygiene. In some cases, however, as in the material on instruction, the beam does tip in a certain direction, though not far, and these cases may be reviewed.

Primary sex contact before marriage is reported in larger proportion by those who feel themselves in better contact with their college associates. It is also reported more frequently than the central expectation by those who feel that in general they work better with others than by themselves. Verbalistic tendencies are similarly related to the establishment of this contact, as is further, not unnaturally, the freer tendency to spend money. The more emotionally labile individuals also report more than their share of these episodes, and it may perhaps be specifically mentioned that they are only very slightly so reported in relation to general social leadership. A similar relation obtains in respect to this leadership trait and other aspects of the sex life observed.

Considering numbers of sex episodes reported, slightly greater frequency of these is again seen in those of looser purse strings and of freer verbalistic tendencies. The ques-

tion of working better with others or by oneself shows an even balance for this trait, as does also the ease or difficulty of mingling with one's college associates.

In respect to the numbers of women involved in these episodes, a polygynous history in those disbursing their funds more freely is relatively marked, and there is a similar relation to verbalistic tendencies. In respect to the ease of mixing with college associates, this item is neutral.

The situation in regard to prostitutes is of relative interest. Verbalistic tendency, hitherto slightly on the positive side of sex activity, is without relation to this phase of it, as is also the tendency to social leadership. The tendency to spend money freely is negatively related to dealings with prostitutes, and this relationship is among the most marked observed. Those who work better with others restrict their activity to non-prostitutes further than do those working better by themselves; and the same is true of mixing well with college associates.

In sum, the so-called extravert traits of the freer talker and spender show a certain consonance with freer sex activity. Prostitution maintains the midway position between autoerotism and strictly heterosexual activity that psychological, and economic, consideration would assign to it. We see in these men a tendency of the extravert traits to be rather associated with the establishment of various primary contacts before marriage. Association with non-prostitutes also denotes a more extraverted type than association with prostitutes.

It will be understood that the present distinction of prostitute and non-prostitute is one of rhetoric and statistics. The term prostitution connotes the motive of economic gain, the other a sex expression as such; and some element of both may be present, both within and without the socio-legal sanctions.

There is an item in the replies serving as a gauge of the general level of satisfactions at which the individual lives—the question whether the predominant spirits are buoyant, medium, or sober. Considering this item as related to sex expression, the scale tips slightly in the direction of more buoyant persons with sex contacts before marriage, of greater

numbers of such contacts, and of more women with whom these contacts have been had. In conformity with what has already appeared concerning prostitutes, the buoyant replies show somewhat less contact with prostitutes than the remainder. This would account for an erratic situation between the sober spirits and numbers of women, such individuals owing their polygnous contacts mainly to prostitution. Buoyant persons show relatively less frequent episodes than the other groups, for the year preceding the inquiry.

On examining this item also with reference to instruction, one finds a deficiency of sober spirits among the instructed and an excess among the uninstructed. This may be because the former come from environments of better mental hygiene generally, and as such less subject to taboos on sex instruction.

The principles that dominate the instruction of to-day are substantially those formulated by St. Paul in the sixth and seventh chapters of First Corinthians, and, in the customary adjectival form of the apostle's name, may be conveniently termed the Pauline morality. Independently of Pauline authority, similar restrictions of sex activity have been attributed to at least the earlier Roman and Germanic civilizations; and it is reasonable to suppose that this was associated with the rôle these peoples have had in history. It is a commonplace that, given groups of the same order of intelligence and energies, that one is better equipped for survival which restricts the life of organic hedonism and turns its resources to pursuits of economic or military value. Time and again destiny has led from Capua to the Metaurus and thence to Zama and destruction. But this sanction is of a social character. From the point of view of individual mental hygiene, it is modified by factors of less ready recognition. There is a parallelism which may be utilized at this point between sex reactions and tobacco or alcohol, because while the mechanisms are similar, the feelings investing the latter are less intense. Brill has made the point that as special addictions of this character often represent the absorption of energies from other fields of more survival value, they may also represent an overplus of energy that cannot be turned to other account, in the presence of marked capacities of good survival value. Efficient persons who are heavy smokers and drinkers

are surely known to all. On the other hand, there are those who cannot tolerate relatively small amounts of alcohol, and who never accustom themselves to the use of tobacco, though able to make in general reasonably adequate social and economic adaptations. It is interesting to compare the accounts of Peary and of Amundsen on the use of alcohol in polar exploration. So in the sexual sphere one recognizes several sorts of constitution: those who crave markedly and tolerate well, who come to psychiatric attention mainly through the medium of luetic invasions of the nervous system; those who crave moderately and tolerate well, whom only the accident of venereal infection brings to clinical attention at all on this score; and those who crave moderately or markedly and tolerate ill, who are of more clinical importance. Two mechanisms of supernormal activity are discernible for the sex life; for individual mental hygiene one is vicious, a depletion of energies disposable in the struggle for existence; the other not individually vicious, the expression of an organism overactive at all levels.

Four cases are cited as "typical" only in the sense that Bunyan uses the word of Esau's birthright as a symbol of a wider range of similar phenomena. Type is a noxious word in psychology, being often confounded with species, as, for example, in the introvert-extravert categories.

There presents himself a neatly dressed young fellow of twenty-five, good-looking, with a manner that gives the appearance of alertness. He has a normal educational history and a Stanford I.Q. of 93, slightly above adult average. He is a bundle of neurotic symptoms, phobias, and obsessions. He is economically inefficient, holding a job six weeks on an average, owing to his "nervous" habits. His sex life has been a prominent feature, with masturbation early and often and heterosexual contacts prior to fifteen years of age. These have been uniformly of the prostitute level—masturbation *per vaginam*, no attachment for any particular individual—there being involved by his own statement not less than 120 women. In this he is not a figure of the "neurotic Don Juan" mentioned by the psychoanalysts; he is not seeking a mother representative, with real attachment while the affair lasts; the arrest is at a lower level, scarcely above the strictly auto-erotic. His energies were firmly fixated at these crude levels and there was not elicited sufficient stability of purpose to effect any perceptible sublimation.

This situation may be compared with that of a man of about thirty, whose sex episodes are less numerous, but also much less tolerated in his special *milieu*. Almost the first item in his story is the ascribing of his present difficulties to having failed to utilize the occasions for primary sexual contacts pre-

sented in his college days. He explains how the emotional stresses now involved are too great for him to manage, but would not be if he had then got them out of his system. He is moved altogether to tears by these recollections and complains bitterly that many of his fellows partake freely of the feast of Venus without interference, but whenever he would snatch a few poor crumbs from her conspicuous table, he is called sharply to account and deprived of his liberty. From a general standpoint the case is a cyclothymic, his disapproved conduct being a part of a hypomanic reaction; the rationalization is an interesting development of the "wild oats" convention.

Another sort of adaptation is presented by a man of twenty-four, whose economic competence is at least equal to self-support, and who offers no complaint of difficulty with associates. There has been no use of alcohol or tobacco, and apparently no masturbation until twenty-one, since when it has taken place about weekly with fancies, the enervating effects of which are part of his complaint. The general picture is one of hypochondria. Recently there has been contact with women at the "petting" level, but it bears the aspect of a "protest" reaction rather than fundamentally motivated. ("Men do these things. I must also, to show that I am a man.") This is a man in whom the sex life remains at a more infantile level than in either of the preceding, but also its demands are less, and more energy is available for meeting other demands of the environment, economic or social. There is no reason to bring this fact under the concept of Freudian sublimation. With such a person the chief risk is that the influence of more heavily sexed associates will lead him into a type of heterosexual adjustment that he is not equipped to support. Adjustment at the level of normal marriage would be very difficult for this man; but in general his adaptations are clearly better than in the preceding cases. His clinical contacts appear to have accomplished a good deal for him, especially in the control of auto-erotism.

In a girl of eighteen of quite marked attractions who came to attention through unmarried motherhood, it developed that this was the first awkward consequence of a series of episodes since the age of about ten, involving perhaps a dozen individuals of the opposite sex. She had a Stanford I.Q. of 119, failing one test in the scale; and her work in non-language tests was of similar order. She was prominently identified with associations endeavoring to represent the best level of mental hygiene for adolescent girlhood. The introduction to such of her confidences as it was possible to gain was the ability to disagree intelligently on a technical point in open-air cooking. From the point of view of general reactions, they were such as one might wish his own daughter to exhibit should she ever find herself in this difficult situation. It is all but certain that for every case that comes to attention, there are many of whom the psychiatric clinic never hears.

The above illustrate inferior adjustments in men with sex life of moderate or marked expression and a general superior adjustment in a girl with much more expression than may be regarded as normal. For good adjustment in men on the basis of free expression, or in women where it is restricted, clinical citations do not seem apposite. The essential point

is the wide range of individual differences so neglected in the conventional teachings.

In view of the patent limitations of questionnaire study, it was endeavored to supplement the material on this phase of it by the best other available means, the analysis of personal acquaintance by another judged competent therefor and by the writer. Those men were listed who, through their own qualities and our acquaintance with them, had made distinctive and valued contributions to our lives, and with whom our acquaintance was sufficient to form satisfactory estimate of their overt sex activity. The total of both lists, my colleague's and mine, is 45 persons; not more than one or two can be present in both. There were observed no evidences of departure from the Pauline morality in some two-thirds of these individuals, while they do appear in the remainder. The proportion is about the same as that of those with pre-marital sex contacts among the students observed. The type of overt sexual adaptation disclosed no general relation to whether the individual appeared to us as a superior personality. It is open to the objector to cite Bishop Horne's reply to David Hume.[1] The harmony of the two sets of data may be urged as mutually supportive.

It is futile to speculate whether persons of one type might have made greater contributions if there had been more complete sublimation of their sex reactions, or whether those of the other would have led fuller lives if this phase of their personalities had been more prominent. Without questioning the reality of the sublimating process, it must differ enormously in different persons, and the means of controlling it are still very doubtful.

Individual mental hygiene is accordingly but little available as sanction from scientific ethics for any specific conduct of the sex life. It has served as such, from the strictest Paulinism to the quondam psychiatric suggestion of sexual abstinence as an etiological factor in dementia præcox. From

[1] The philosopher had ventured the remark that all devout persons he had met were melancholy, which the theologian criticized upon two grounds: first, that the other's experience was an inadequate sampling of devout persons, most of his acquaintance being individuals of quite different persuasion; and that, further, the aspect of David Hume was such as to induce melancholy in any devout person who saw him.

a physiological standpoint, the Pauline sanctions derivable from venereal disease have not been overstated, and can be effectively reinforced by clinical demonstrations of general paralysis, when a nearby institution renders them accessible. The main drawback of this teaching has been to neglect the means by which these risks may be modified.

Sanctions are also sought for the Pauline morality in men, on altruistic grounds of special damage done to the partner's life. These, whatever their ethical appeal, have a questionable psychological basis. Adult clinical psychology brings one into many contacts with individuals traversing the road said, in Binet phraseology, to be "down hill all the way to the city and down hill all the way back home". It has offered little or no ground for supposing that episodes of this character are as such more demoralizing in women than in men. In anthropology and social history, the effects are an artefact of the *mores,* sometimes degrading, sometimes the reverse.

The problems of sex adjustment, as related to the social conditions that surround us, are dominated by the dual, and at times inconsistent, rôle which this set of impulses is called upon to play, in the perpetuation of the species and the personal adaptations of the individual. Though in certain specialized groups, many may not find, or soon cease to find, average values in these spheres, our social psychology in general places these values among the most important in secular experience. They bear directly on those problems of population pressure and race betterment which are of concern to many who look upon progress in psychological rather than physical terms. In a race psychology such as ours, constructive eugenics has little chance unless these personal values are safeguarded. There may be some help in a better understanding of them, such as is sought in the work of Ellis, in some highly significant accessions to be anticipated from another branch of the Council's efforts, and in society's recent experimentation on its own account, a cross section of which is offered in the present studies.

I have no wish to pose as an obscurantist in matters of sex instruction through verbal means, but it is easy to expect too much of it. The instruction obtained by the group under discussion appears neither to have modified sex life nor to

have improved general adaptation in significant degree. It is true that the instruction was probably fragmentary and one-sided. Evidence is also accumulating that certain adjustment difficulties in mature individuals are helped by a type of information which goes much further than the ordinary conception of "adequate sex instruction" at the adolescent level. But except upon the groundwork of familial fixation, bio-chemism, and the stimulus of the environment, the content of information here evaluated shows a minor rôle in ordering this phase of one's life. Perhaps the chief gain from it is through a degree of mutual understanding between young and adult such as can seldom be hoped for where this topic is taboo. It must recognize, however, that individual differences are not less real in this sphere than in simple reaction time, and that its secular problems are not met by any single principle of adjustment, be this according to St. Paul, or Cleopatra, or the Maid of Orleans, or Julius Caesar.

THE NEUROTIC GOAL IN POST-WAR NEUROSES*

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ADLER, in his book, *The Neurotic Constitution,* lays the foundation for his all-embracing theory of the etiology of the psychoneuroses. He believes that the underlying cause of every neurosis is a feeling of inferiority based upon an organ inferiority which may or may not be recognized as such by the patient or his friends. The neurosis is the patient's method of compensating for this feeling of inferiority. Adler believes that the neurotic goal reveals itself to us in a heightened ego consciousness, whose simple formula is, "I wish to be a complete man." He refers to this formula as the "masculine protest".

The neurotic spends his life trying to prove to himself and to others that he is not inferior, but superior. He thereby overcompensates and develops his characteristic personality and his psychic and somatic symptoms.

We have observed that the neurotic, in attempting to achieve his goal, plays up to his desired position in every possible way. He dresses in accordance with his ideal, assumes a suave manner, and is prone to use big words and high-sounding phrases. There is often an indefinable lack of sincerity about him. It is as if he were playing rather poorly a part in a colossal melodrama, and one is reminded of Shakespeare's line, "The lady doth protest too much, methinks."

In our work with psychoneurotic ex-service men, we have found the neurotic goal frequently illustrated by their industrial records. Many adjusted well before the war in spite of their neurotic constitutions, but when they enlisted or were drafted, they were torn from their relatives, friends, and jobs,

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and forced to adjust to a new and frequently an unpleasant environment in the training camp or battlefield. In spite of the hardships, life was full of interest and excitement. They made new friends and new acquaintances, many of whom were men of superior training and accomplishments who in civil life had belonged to a much higher social class. In the army, however, class distinctions were forgotten and they met these social superiors on an equal footing. From their new acquaintances they acquired new points of view and new ambitions, which were frequently far beyond their ability to attain.

Upon returning to civil life, they adjusted well for a time, for they were treated as returned heroes and naturally were not expected to work. Gradually, however, the excitement and patriotic fervor died away, and they donned their civilian clothes and returned to work, often at their pre-war occupations. The contrast was so great—life was so dull and uninteresting—it is no wonder that some of these neurotic men became restless and felt themselves superior to their old jobs.

In the readjustments that followed many secured better positions than they had previously held. Those who had the ability, preliminary training, and persistence succeeded. But many failed for lack of one or more of these qualities. This failure caused or accentuated their feeling of inferiority and frequently a neurosis developed. Those who had been seriously ill or wounded during military service naturally blamed their failure to their real or imagined loss of health. Others who had not been ill blamed the stress and strain of military life for all the neurotic symptoms that accompanied and followed their industrial failure.

Unfortunately the attempt of the government to aid them in their readjustment sometimes had the opposite effect, for many men were given training in the vocations which they chose (in accordance with their neurotic goals), but for which they were not fitted either temperamentally, intellectually, or educationally. Failure during or after training only served to aggravate their neuroses. The following cases illustrate some of these points.

Case 1. W. S. V. is thirty-five years old and married. He was born in Germany and came to America when very young. He finished grammar school and attended a business school for two years, but did not

complete the course because of special disability in mathematics. While in France, he was " shell-shocked " and exhibited an hysterical fugue. He was returned to the front, but was in constant fear and soon thereafter was hospitalized for pain in ears, back, left hip, feet, and head. He remained in hospitals continuously from November, 1918, until discharge from the army in March, 1919.

His industrial record is of especial interest. In spite of the fact that in grade school and in business college he had much difficulty with mathematics, especially mental arithmetic, he always chose occupations that required rapid mental calculation. Before the war, he was a bookkeeper in lumber yards, but was not very successful at it. " There's a lot of figurin' in a lumber yard, and when I had to assume any responsibility, I worried. I felt that I didn't have the ability in estimating and I got so I couldn't even sleep. I'd lie awake all night thinking about the figurin'."

After discharge from the army, he was given vocational training in building and construction work, estimating and drafting. "It was kinda hard for me. Then I worked two and a half years as an accountant for a general contractor. I was really incompetent there, for I was a little too slow for the estimating. Then I broke down and went to the hospital." He has been in hospitals most of the time since with vague symptoms of headache, backache, restlessness, and anxiety. No physical cause has been found for these symptoms. He wonders if he is feebleminded, or if he is deteriorating mentally. (His mental age is 15 years and 9 months.) Emotionally, he is sensitive, self-conscious, stubborn, critical, and fault-finding. He is introspective and seclusive. He has a rather haughty bearing and apparently wishes to create the impression that he is quite different from the average patient.

This man illustrates well the evils of industrial maladaptation and apparently his neurotic goal has kept him from choosing an occupation suited to his ability, and repeated failures have precipitated a neurosis which is his present means of defense. He still refuses to consider occupations for which he is fitted, but insists that he wants to be a contractor. Perhaps intelligent vocational guidance at the proper time would have prevented the present neurosis. Unfortunately he was placed in a position that called for high-average or superior intelligence with good ability in mathematics, whereas he rates only as a low average and has a special disability in mathematics. The inevitable failures that resulted still further aggravated his neurosis.

Case 2. C. H. F. is thirty-two years of age and single. His mother died of tuberculosis when he was very young, and he grew up in the home of his grandparents, where he was coddled and allowed to have his own way. His health was the object of much concern, as his grandparents were very much worried lest he also have tuberculosis. Thus very early he learned to utilize his symptoms to get what he wanted.

His chief neurotic symptoms prior to military service were a speech defect of the letter-substitution type, commonly known as "baby talk"; dislike of many common foods; inability to whistle; and bashfulness. He, however, reached the second year of college and made a fair industrial adaptation. His war service was uneventful. He did not go overseas and was not ill while in the army.

After the war he did not return to his pre-war occupation of auto mechanic, although he had succeeded at it and had had further training along that line in the army. He said that the work was too dull and the pay too small. The first work he tried was in a factory, building auto tires a few weeks at a time. "I couldn't stand it, and I quit." Then, in 1920, he worked as a service contact man for a garage for about three weeks. "Too much actual work, see?" Then he worked for a while for a cash-register concern in their classrooms and repair shop. "I saw I wasn't getting anywhere and I quit. I'd smash stuff and things like that." He did not work for a year and then put in a claim for compensation with the Veterans' Bureau. The diagnosis and rating he received did not satisfy him and he has tried ever since to get a higher rating. In 1923, he worked a couple of weeks as inspector for a large motor company, but found it "tiresome and more work than you would think for". In 1924, he tried working as a traveling salesman. The work proved too hard and he quit after a few weeks. His goal is a job with the minimum of work and a good salary. Any position that does not come up to this standard is beneath him. He prefers being idle to accepting a "soft job" with corresponding pay and says, "I can't do manual work. I want to get a business job."

The symptom that he uses to excuse his idleness is that of cardiac discomfort. Careful and repeated physical examinations and electrocardiographic and roentgenographic study reveal a very minor organic disease of the heart, not severe enough to interfere with ordinary work. He enlarges upon his symptoms in a morbid fashion, and seems to take great satisfaction in them.

Psychotherapy was attempted, but met with bitter opposition. In spite of the fact that he has a high intelligence quotient (mental age 17 years, 1 month; I.Q. 107), it seems impossible to give him any real insight into his condition. This is doubtless because of internal resistance connected with his feeling of inferiority. Real insight would be unbearable. He keeps off friends and foes alike by his gruff, irritable, fault-finding manner, and by this means shelters himself from their criticisms and their suggestions.

Case 3. T. A. is thirty years old and single. His father was a successful timber contractor and dealt in transactions that involved large sums of money. He was born in Tennessee and went to school in a small city. He attended regularly until he was fifteen years old, but completed only the fourth grade. (His mental age is 11 years, 10 months.) His account of his industrial record before entering the service is very fragmentary, and it seems that he does not wish to recall the details. He remembers only that just before enlisting he was his father's chauffeur. While in France, he developed a neurosis, the exact nature of which cannot be determined. He thinks he was somewhat confused and a "little off, mentally". Since the war, he has twice attempted, on a large scale, to carry on a taxi and bus business, but

failed each time because of overwork and poor judgment. At another time, he equipped, at a large expense, a moving-picture theater, but failed in that enterprise also. In addition, he worked at several different factory jobs for short periods, but did not continue because the noise and confusion got on his nerves. All of these enterprises were interspersed by periods of hospitalization for vague symptoms for which no physical cause could be found. He would remain in the hospital as long as he could and save his compensation and, when discharged, would invest it in some new enterprise.

In the course of psychotherapeutic talks, he expressed the desire to be a big business man like his father. He said many times, "I'm not a gold-bricker like some of the other patients. I've made good money on the outside and would leave at once if I had my health." He felt himself superior to regulations and would frequently break hospital rules with regard to passes. It seems certain that his neurosis is the result of the discrepancy between his ideals and his achievements.

This case illustrates the eternal conflict of the son with the father. Every boy's ambition is to equal or surpass his father. Failure to do so lowers his pride and, in the neurotic, symptoms arise to excuse the failure. The factor of mental deficiency also plays a large part in this case. One of the remarkable things about modern life is that so many find their proper level and so few are misfits. The selection is made by the wasteful method of trial and error. Finding his niche is especially difficult for the mentally inferior neurotic, for the failures which are inevitable, if he aims too high (as he usually does), aggravate his symptoms and make future adjustment very difficult.

Case 4. D. M. C. is twenty-seven years old, has an excellent physique, and is so attractive in appearance that he is often mistaken for a college athlete. His parents belong to the class known in the South as "poor white trash"—that is, they have no social or economic status and are generally shiftless. As a child he showed several neurotic traits, the most important of which were stubbornness and a speech defect. He attended school from six to ten, but did not complete the second grade. Psychometric tests give him a mental age of 10 years and 11 months, with an intelligence quotient of 68, which places him in the moron group. Before the war, he spent most of his time working on a tobacco farm for his father, who was a tenant. He also worked for a year in a soda fountain and for six months on a road-construction gang.

In 1915, he enlisted in the National Guard and went overseas in 1918. He had no serious illness in the service and enjoyed life in the training camps. He became very nervous and frightened when placed on the front lines, but carried on for two months until knocked down by an exploding shell, after which he was unconscious for thirteen hours. Thereafter, his speech became very much worse and he asked to be returned to the rear. His request was refused. Soon after, he was

wounded slightly on the hand and was hospitalized from that time until discharged from the army a year later.

Since discharge he has had vocational training in common-school subjects for several months, in agriculture, in auto mechanics, and in vulcanizing, and has failed in each of these projects. Each job he tried proved too hard for him, and an emotional upset accompanied each failure, with a return of his stuttering and "nervousness". He has been hospitalized five different times in this hospital and three times in an old soldiers' home and has received treatment in two other speech clinics as a trainee. Each period of treatment was temporarily successful in relieving all of his symptoms, but a relapse occurred as soon as he attempted an adjustment in the outside world.

This case is the best illustration we have seen of the practical philosophy underlying the popular song, "How you gonna keep 'em down on the farm after they've seen Paree?" He was able, as we have seen, in spite of his low mental-age level and his neurotic traits, to make a fair adjustment to his simple environment before service, and it is probable that if there had been no war, he would to-day be a happy and contented farm hand in the tobacco fields. After discharge, he exhibited his neurotic goal by being unwilling to accept any but "white-collar" jobs. He naturally failed at these because of his low intelligence. He felt insecure and inferior and his psychoneurotic symptoms developed as a defense mechanism for this feeling of inferiority. The attempts of the vocational board to rehabilitate him also failed because they did not take into account his mental age, and these failures tended to aggravate his neurosis. When placed in jobs for which he is really fitted, his feeling of inferiority becomes so accentuated that his nervous symptoms reappear. Hospitalization offered an escape from all unpleasant situations, and he has freely availed himself of his opportunities in this direction. In the hospital his symptoms disappear and he dresses up and enjoys life generally. His good appearance and his excellent ability to dance make him a veritable social lion. Dancing seems to be a compensation for his feeling of inferiority, for his stuttering almost disappears on the dance floor. In fact, this is the one situation in which he feels himself superior.

In this paper it has been our policy to speak quite plainly, as we feel that a clear understanding of the problem is necessary before attempting its solution. We do not, however, sympathize with those who blame too severely the neurotic

for his industrial failure or for his attempt to obtain compensation and hospitalization. His conduct is the resultant of a complicated set of forces, most of which are beyond his control. He, of course, does not realize that his symptoms are the result of, rather than the cause of, his failure.

The wisdom of the present legislation which grants compensation to psychoneurotics can be and has been debated. However, since there is such a law, we have no choice in the matter, and its provisions should be justly carried out. Little progress can be made in treatment if the neurotic feels that he has not been treated fairly. On the other hand, compensation should not be too liberal, nor hospitalization too prolonged. Frequent changes in rating tend to upset the neurotic patient. It would be better to give him a permanent partial rating, as one would a claimant for the loss of a limb, and inform him that no change will be made in this rating. He would then be much more likely to make a satisfactory social and industrial adjustment.

It is perhaps unnecessary to say that every neurotic should be given a very thorough examination to rule out physical disease. Very frequently an obscure organic basis is found for some of his symptoms. If this is amenable to treatment, it should be treated. If, on the contrary, nothing can be done for it, the facts should be explained to the patient. Frankness is essential, for, as Tom Williams has said, "A dreadful certainty is better than an uncertain dread", and a neurotic can adjust better to a known disability than to a misunderstood symptom.

Although we have employed psychotherapy in these cases, we have usually failed to give them much real insight. They have surrounded themselves with a well-nigh impregnable fortress of symptoms and rationalizations. We feel that the best solution of the problem lies in the field of vocational guidance. An attempt should be made to place the neurotic in a situation for which he is qualified. If he once succeeds, his symptoms tend to disappear, for a fictitious feeling of inferiority is incompatible with the fact of success.

SAN JUAN DE DIOS FINDS FOLLOWERS

MENTAL HYGIENE IN SPAIN

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* EDITOR'S NOTE: Mr. Brickell, who at the present time is traveling in Spain, has for a number of years followed closely the work of The National Committee for Mental Hygiene and the development of the mental-hygiene movement in the United States. His first contact with the work of the committee was in 1918, when the committee made a survey of the care and treatment of the insane and feebleminded in Mississippi, at the request of Governor Bilbo. Mr. Brickell was at the time the editor of an influential paper in the state. He was one of the first of the public men of Mississippi to see the importance of the work the committee was doing for the state, and upon the completion of the survey saw to it that the report and its recommendations had wide publicity through the press of the state. In consequence the people of Mississippi were fully informed and the major recommendations of the report were put into effect. On joining the staff of the *New York Evening Post* in 1919, Mr. Brickell sought out the offices of the National Committee and volunteered his assistance in the educational work of the committee. This was readily accepted and Mr. Brickell has since rendered valuable services to the committee as an adviser in certain of its educational activities.

IT IS generally accepted as a fact that the first asylum for the insane—hospital would be an inexact word in this connection—was established in Granada by a Dominican friar, San Juan de Dios, so that Spain may fairly claim to have started the mental-hygiene movement.

It was in 1300 that the good friar used to go daily through the streets of his Andalusian city with a bell and a basket, begging alms for his sufferers from mental disease. He did no more, of course, than furnish them with food and a roof over their heads, but one has to know only a little of the feeling toward the insane that prevailed during his century to appreciate his courage and to realize that he was the forerunner of a long line of men and women who have devoted their lives to improving the condition and the care of mental sufferers.

Unfortunately, Spain has progressed little if any in the care of the mentally ill since San Juan de Dios started his asylum. The monks of his own order care for the insane

to-day, receiving a small sum for each patient from the government. Such a thing as modern psychiatry is virtually unknown, and that statement carries with it the implication that the abuses familiar to all students of the history of the care of the insane persist here to-day in their worst forms.

There are just now some signs of a change. Psychiatrists with American and German training are beginning to multiply, at least in the larger cities, and from one of them, who is coming to be widely known for his work with the mentally ill and also with subnormal children, I got my information about mental-hygiene conditions in this country.

He is Dr. Gonzalo R. Lafora who, after completing two and a half years of work in the government hospital at Washington and in New York clinics, returned to Madrid some three years ago and established the first private sanitarium for nervous and mental patients. He is just now completing a private school for subnormal children.

I had the pleasure of an evening's chat with him in his home, and the distinct pleasure of hearing him say that there were many signs of an awakening of interest in modern mental hygiene throughout the larger cities of Spain. It is likely, in fact, that a meeting of neurologists and psychologists will be held either in Toledo or Madrid this summer for the organization of a society for mental hygiene.

Through his contacts with the mental-hygiene movement in France and Germany, Dr. Lafora is well informed on the work of The National Committee for Mental Hygiene, and expressed the greatest admiration for the progress that had been made in the United States during the past two decades.

"When I returned to Madrid to begin my practice", he said, "I encountered the familiar prejudice against psychiatry—that is, the familiar desire on the part of the families of mental sufferers to keep their trouble a carefully guarded secret. While this prejudice remains, especially among the upper classes, the situation has altered very materially. My sanitarium is full all the time, and I have a long waiting list.

"The psychiatrists of Madrid, and of Spain generally, do a great deal of charity work, of course, and we find the poorer people—the peasants—not only willing, but delighted to take advantage of every opportunity we offer them, and quite

ready to bring incipient nervous cases to us in time for us to help them.

"There is no preventive work in Spain whatever except for these privately operated clinics. In the general hospital here there is a psychiatric ward for thirty men and thirty women, but no patient is allowed to remain more than one month.

"As might be expected, our asylums are generally badly overcrowded. There is only one government hospital, which is situated near Madrid; for the rest of the country there are provincial asylums where the care is of the most primitive variety. The attendants are usually of a low order and cling fast to an old superstition that the more the patients are beaten, the sooner they will recover. The straitjacket is the only method of dealing with disturbed patients and the usual chain of abuses and cruelties is to be found practically without exception in all our asylums.

"On the legal side, our last laws were passed in 1848 and are of the most primitive character. Commitment is extremely difficult, and so bound up with legal red tape that the laws completely defeat their own ends. Police officers are not allowed to handle the violently insane, which means, of course, that many dangerous persons are allowed full liberty. We are without the observation wards that are so valuable a part of your American system."

It had interested me very much in my travels through Spain, both in the small towns and the cities, to observe that despite the widest possible prevalence of every known variety of liquor dispensary, I had not seen any drunkenness. I asked Dr. Lafora about alcoholic insanity in Spain, remembering what a serious problem it has been—and is—in the United States. The reply was:

"With us, alcoholic psychoses are virtually non-existent. They are among the rarest forms of insanity in Spain. In the mining districts of the North and the industrial regions of the South, one finds a few cases, but generally, it is no problem. Nor are we bothered to any extent by narcotic psychoses. During and just after the war there was a sort of fad for drug-taking, but it has passed. The masses in Spain are forced to be temperate. They have not the money to spend for drink, and there are, therefore, few drunkards."

There are other reasons, too, why these people are so temperate, although the economic factor cannot be overlooked. In six weeks of living in Madrid, during which I have gone about a great deal among all classes of people, I have not seen so much as one person who had had too much to drink, and in the cafés the vast majority of men drink coffee with hot milk, sometimes with a little brandy, more often not. In the saloons, they will sit for an evening over a pony of anisette or a small glass of cheap wine.

Venereal disease is widely prevalent in Spain, but here again we come upon a rather surprising state of affairs. Despite the fact that syphilis is widespread, there are strikingly few cases of paresis in the hospitals and Dr. Lafora says the condition is rarely met with. In the large hospital of Ciempozuelos, just outside Madrid, a recent statistical study showed that of 1,200 male patients there were only 25 cases of general paresis, and of 900 women, only 8 cases.

There are four venereal-disease clinics in Madrid, organized along the most modern lines and giving free salvarsan treatments. Gonorrhea is, of course, the cause of an appalling amount of blindness in Spain, and the problem of the blind is no less acute and moving than that of the insane.

Prostitution is licensed, and as is usual in continental countries, there is a system of examination. Remembering some studies I had read of conditions in France and Germany, I asked Dr. Lafora if the examinations here were as farcical as in most other countries. He said they were carefully enough made, but, as usual, did not reach the poorer class of prostitutes with sufficient thoroughness to be any guarantee against the transmission of venereal disease.

In the direction of the prevention and cure of venereal disease, Spain is not so laggard as in many ways. Lectures on the subject have been given throughout the country within the past few years, and a conference was held in Barcelona last year which is expected to result in the establishment of more clinics and a greater impetus to the educational movement.

Spanish psychiatrists have to leave their country for training, as there are at present no schools that offer courses. Many go to Germany—it is a little surprising on one's first visit to Spain to find just how close the *rapprochement* between

this country and Germany really is—while others get their training in the United States.

When Dr. Lafora established his private sanitarium, it was a difficult problem to find nurses and none were to be had with any training. So he set up his own training school, using peasant girls for the most part, uneducated and ignorant, but fine human material, and he has found them very capable. One of the remarks about Spain and Spanish people one hears most often, both from the lips of the native and the foreigner who knows the country, is: "The peasant is the real aristocrat of Spain." It is a remark one can fully endorse from one's own experience.

The most widely prevalent form of insanity in Spain, Dr. Lafora said, is schizophrenia, which makes up more than 60 per cent of the cases that come under his observation.

Dr. Lafora, with several other psychiatrists, edits a mental-hygiene quarterly, *Archives de Neurobiologia,* and writes widely on Spanish aspects of mental-hygiene problems. He is as keenly interested in the problem of the subnormal child, for whom little or nothing has been done in Spain—there are in Barcelona and Madrid a few pitifully small special classes—as he is in the insane.

With a large and growing private practice and all his other interests, he is an enthusiastic devotee of painting—he painted much himself in his youth—and has written an unusually interesting pamphlet, *Psychological Study of Cubism and Expressionism,* showing the relation of these two modern techniques with the painting and drawing of the insane.

To the American who knows what can be done to bring sufferers from mental disease back to health and who is even slightly *au courant* with the remarkable developments of modern psychiatry, the situation in Spain might at a glance appear well-nigh hopeless. But the mental-hygiene movement as we know it is very young, and with even a few men like Dr. Lafora, there is no reason why this country should not in time honor the memory of the admirable San Juan de Dios by moving up in the van of the nations that have adopted a civilized attitude toward the problems of mental hygiene.

ABSTRACTS

Environmental Handicaps of 400 Habit Clinic Children. By Bertha C. Reynolds. *Hospital Social Service,* 12:329–36, December, 1925.

The children discussed in this article were selected from the first 492 applications to the habit clinics of the Massachusetts Division of Mental Hygiene. The 92 excluded were slight-service cases whose social histories were not available. Otherwise, the cases were taken consecutively. Sixty-seven and five-tenths per cent of the children were under six, 84 per cent under eight, and all but 2.5 per cent under twelve. A few were referred by parents, but the majority by visiting nurses or social workers. Sixty-six per cent came from homes and neighborhoods in which foreign customs were predominant—Italian in 43 per cent of the whole number, Jewish in 23 per cent. About 25 per cent were of American-born parents.

Although the first four clinics were started in what are considered poor neighborhoods of Boston, only one in ten of these 400 children were suffering from lack of physical necessities. But 322 had suffered in various other ways from poverty of environment. A normal home, it is to be assumed, should provide for the child not only food and shelter and care, but also some training in conduct and in religion, some idea of obedience to law, some of the culture of the group to which he belongs, a chance to express himself in play and to mingle with other children of his own age, and affection from his own circle. In 80.5 per cent of the 400 cases, the home failed in one or more of these requirements. In the remaining 19.5 per cent, the homes were considered adequate, the maladjustment being due to other causes—chiefly physical or mental disease or defect, or some lack of understanding on the part of the parents. "In other words", as Miss Reynolds puts it, "not quite 20 per cent were problems for the psychiatrist uncomplicated by serious defects in home life."

In 280 cases, or 87 per cent of the group whose homes were at fault, the failure was spiritual rather than material. Eighty-three per cent of the 280 had apparently received from their parents no teaching as to the meaning of right and wrong conduct; 78 per cent were suffering from lack of effective parental control; 47.8 per cent came from homes that, to all appearances, had no cultural interests; 41 per cent lacked opportunities for normal play and 23.6 per cent

opportunities for social contact with other children; and 10 per cent were unloved.

The lack of training and discipline in this group, Miss Reynolds points out, must be considered in relation to racial setting. Among Italians, for example, the belief is prevalent that children under school age are "too little" to be disciplined, and added to this there is sometimes a superstitious fear that the child will die after punishment, leaving his parents to suffer lifelong regret. It may be that in an Italian village, where the child is early called upon to assume responsibility for younger children, where he comes into close contact with the unyielding forces of nature, and where the organization of family life is more stable, this delay in training is of less consequence than in an immigrant home in a tenement. It is the experience of the clinics, however, that the Italian parents with whom they come in contact are themselves apparently handicapped in their parenthood by lack of self-control, which may or may not be due to lack of early discipline.

The figures with regard to lack of educational advantages mean little in themselves—simply that in the homes in question there was no reading matter other than a foreign or American newspaper. These homes may offer other cultural opportunities in the shape of folk lore and homely philosophy, even a really fine appreciation of music and art, and—in the case of the Jewish homes especially—may imbue the children with a desire for knowledge that sends them out eager to take advantage of the opportunities provided by the school. Yet, from the practical point of view, they go out handicapped, with minds either culturally barren or preëmpted by a foreign culture, and very naturally, therefore, may have some difficulties in their school adjustments.

No data were secured as to home training in religion in this group, as it was thought best to avoid inquiries that might arouse prejudice or suspicion. But from impressions gained in visiting and from the fact that conduct training was so generally lacking, it seems probable that there was little religious influence of a vital sort in these homes.

An even more serious problem than lack of discipline is the lack of opportunities for normal play from which one-third of the cases studied were suffering. "In every case", Miss Reynolds states, "a congested city neighborhood was at the bottom of the difficulty. . . . Children are kept prisoners in homes and on doorsteps till the desire for active play is gone out of them or they get old enough to defy their distracted jailer. Parents have seen children picked up bleeding from the path of a truck and they fear. They have not seen the connection between playless childhood and warped, inefficient adult years."

Since contact with other children comes about largely through play, it is not surprising that of the 77 children who lacked such contact 56 were also deprived of play. The other 21 played, but alone or with adults in close supervision. Ten of them had no brothers or sisters to play with; 9 did not get along well with other children; and 2 were excluded from the society of other children because of bad habits.

Of the 33 children who were not receiving the normal affection that a home should give, 13 were definitely disliked by father or mother, 12 were in institutions or frequently changing foster homes, and 6 were suffering from the unhealthy emotional attitudes of mentally abnormal parents.

An effort to get at the causes back of the inadequacy of these homes brought to light certain situations very menacing to the mental health of the children. In 51 cases friction between parents or relatives was an outstanding feature of the home life—in half of these cases connected with drinking, gambling, or lack of responsibility on the part of the father. Mental defect or disease was at the bottom of it in 11 cases, and temperamental differences between the parents in 10. In 14 families it had reached the point of a separation between the parents. Conflicting ideas as to child training had resulted in a serious division of authority in 35 homes, though in 19 of these the parents were amicable about their differences. Other causes of friction were racial or religious differences between the parents, a wide disparity in age, and jarring relatives.

In at least 27 cases—it is impossible to say how many more—there had been early exposure to sex knowledge or experiences in the home. Sixteen children had shared a room with their parents; 8 were known to have had sex experiences with brothers or sisters or companions; and carelessness at the birth of another child had had serious consequences for at least 2.

Approaching the problem from another angle, a study was made of the handicaps of the parents represented. In 225 cases the parents were ignorant to a degree that precluded even a crude interchange of ideas about their problems. In 48 families physical illness was a handicapping factor, the father being unable to work or the mother unable to manage the housework and the care of the children. Mental or nervous disability in one or both parents was a disturbing factor in the lives of 110 of the children. In 18 cases, one or both parents showed a distinct lack of responsibility for the child, sometimes amounting to indifference. On the other hand, 85 children were considered to be the victims of over-solicitude. "There were certain conditions which seemed to accompany this misfortune fairly often. The child was an only child in 19 cases and the only boy in 23 in all. The mother was neurotic in one-fourth the cases. Loss of other

children, widowhood of the mother, advanced years of the parents, unhappy married life accounted among them for another quarter. One-fourth of the children had had much illness or had met with some injury.'' Over 58 per cent of the over-solicitous mothers were Jewish. Here again, as in the case of the Italian parents, the ideals of the community are largely to blame. Jewish mothers are reluctant to put into effect disciplinary measures for fear that the neighbors will think them ''without a mother's heart''.

One of the surprising things revealed by the study was the comparatively small amount of abnormality among the children themselves. Only 6 per cent were diagnosed as cases of mental disease or defect; 13 per cent more were considered by the social worker to have poor personality make-ups; and 32.5 per cent were suffering from some physical disability, such as enlarged tonsils or adenoids, or were in poor physical condition.

There seemed to be a certain significance in the position of the child in the home. Forty-seven were only children; 80 were the only children of their own sex in the home; 108 were the oldest, and 83 the youngest; 24 were adopted or placed-out children; 26 had the misfortune to be the favorite child of one or both parents; 85 were considered peculiar by their families and were advertised as such among their parents' friends.

''The tragic thing about the homes represented in this study'', Miss Reynolds concludes, ''seemed to be that the children were not harmonious elements of a happy, coöperative family, but combatants on a battlefield where usually the laurels were pretty much on one side. In 209 cases they were with the children. The methods used fall into three classes which we may call the method of violence, the method of stubborn resistance, and that of playing on the weaknesses of parents through appeal to sympathy or weariness or fear. A resourceful child might use all of them; 104 relied prominently on noise, destruction, kicking, and striking, 109 on stubbornness, while 152 whined or cried their parents into submission; 27 of the 152 had developed some terrifying physical symptom which made it imperative that they be given their way. More than half of these had fainting attacks or 'blue spells' without physical cause, while others vomited, stayed awake at night, or otherwise awakened parental solicitude.

''In what per cent of cases the parents were the victors is impossible to tell because of the difficulty of distinguishing between normal parental direction and the mistaken control that warps a child's life. Only those cases were listed where parental domination was so clearly unwholesome as to constitute a problem, being either cruel, a manifestation of parental bad temper—and hence not a method of dis-

cipline at all—or else a control by fear. In the latter instance statistics mean little, since obedience is not a test of the child's being really controlled. Fear based on threats which amount to nothing sometimes evaporates, leaving a cynicism which may obey, but leaves its possessor quite the victor in the contest. However, we felt that 22 of the 400 children were dominated by fears, of which the most common were those of punishment or the bogie man in some form, 21 by physical punishment, 24 by lying promises and a few, 17, by sheer force of will or by emotional appeal to be good because mother was ill or for love of her. This latter form is capable of great abuse, as in the case of one fine lad with a good mother whose need of wholesome play and companionship with other boys of his age was being placed in false conflict with his real love for his mother. The fits of stubbornness by which he reacted to the pull in two directions were still further used against him as evidence that he was not a loving son. Mother love may curse as well as bless. If it does not fit its dear one for other loves and sterner realities, it kills instead of giving life.

"This study reveals a tremendous educational problem. If more than half the parents of these children were too ignorant to live understandingly in the world of common life, if 80.5 per cent of the children failed to find adequate home care, including training in conduct for living with other people, what can be done about it? Almost universally the parents were ignorant of some of the simple, commonsense principles of child training. In addition to trying to furnish a skilled diagnosis of what the real trouble might be underneath a bewildering complex of symptoms, the clinic was kept busy teaching such simple ideas as, 'You cannot lie to your child and expect him to go on believing you', or, 'Bribing is only payment for wrong doing', or 'Fear controls for a little while, but either hardens the child or makes a coward of him in the end.' These ideas ought to be as much a part of common knowledge as the use of milk for babies, and, if they were, would make a large part of the habit-clinic work unnecessary.

"When we, as a people, care supremely for the upbringing of our children, care enough to provide training for young people in parenthood as carefully as in reading, writing, and arithmetic, when we believe in play enough to see that no child misses it because of the accident of living in a city wilderness, when we learn enough about living together to prevent our quarrels from embittering our children's lives or our foolish love from sapping their vitality, then perhaps we shall be fit to be the guides of the children of the future."

STANFORD'S PROGRAM OF UNIVERSITY PERSONNEL RESEARCH. By Lewis M. Terman and Karl M. Cowdery. *The Journal of Personnel Research,* 4:263–67, November-December, 1925.

Stanford's program of personnel research grew out of an experiment instituted in 1921 as the result of a realization that the university was spending $335,000 a year—about one-third of its instructional budget—in the attempt to educate unsatisfactory or doubtful student material. In order to find out how far the unfit could be singled out by intelligence tests before matriculation, it was decided to require the Thorndike intelligence examination of all new undergraduate students. The scores attained were to have no effect upon matriculation, but were to be correlated with the students' university records. In 1923 the committee in charge of the investigation reported on the results and recommended that the Thorndike test be made a permanent entrance requirement, that students scoring below 50 be denied matriculation, and that scores be taken into account in filling the quota from candidates who exceeded 50. The resolution was adopted, and in 1924 the selection of students by means of the tests was begun.

Apparently the new requirement had the immediate effect of frightening away some of the dullards who would otherwise have applied, for while the average score of *matriculated students* in 1921 and 1922 had been only 71, in 1924 the average score of *applicants* was 75.36 and of *accepted candidates* 78.7, and in 1925 the score of *applicants* was 77.1 and the score of *accepted students,* though not definitely determined at the time the paper was written, promised to be 80 or higher. That is to say, the average score of entering students has been lifted about ten points in two years, and applicants who rank among the lowest tenth of the former student body have been definitely excluded from the university. "By giving suitable publicity to the fact that Stanford is in the market for brains", the authors state, "and by slightly increasing the weight given to the intelligence score in the sifting of applicants, it would be possible to set the lower limit at what was once our average, and to bring the average to a point which was formerly reached by only 10 or 15 per cent of our student body."

The effect of the new requirement upon the student body has been almost as marked. During the year 1920–21, 30 per cent of the student population were placed upon probation or were disqualified on account of poor scholarship, and the average percentage for this and the three following years was 28.5. In 1924–25, the first year in which the intelligence tests were used in the selection of new

students, the percentage of students who came to the attention of the authorities because of low scholarship was only 21.8.

In 1925 a new step was taken in the appointment of a director of personnel research. The only prescribed duties attached to this position were the taking charge of entrance intelligence examinations, the recording and reporting of results, and the comparison of scores and scholarship records. Otherwise the director was given practically a free hand to make of the position what he could. The plans for the first year included the inauguration of special-aptitude tests and the continuation of work already begun on the statistical evaluation of various items in the application credentials and on the diagnosis of vocational interests.

In discussing the tests of vocational interest that are being investigated, the authors raise the question "whether specialization of vocational interest is not readily discoverable by introspection and self-observation without the aid of tests". Their answer is emphatically no. "The youth has no certain intuitive knowledge as to the psychological nature of the interests which characterize successful men and women in the several professions. Moreover, he is often misled by parental bias, by the personal interest of a favorite teacher, by incomplete and inaccurate knowledge of vocations, and by numerous other circumstances of environment and training. Perhaps half or more of our college freshmen are very uncertain regarding their vocational interests, and the findings of one of the writers (Cowdery) indicate that some who feel fairly certain are probably in error."

Plans are being made also to institute a series of special-aptitude tests, such as the Seashore tests of musical ability, the Thurstone tests of engineering aptitude, and other special-ability tests as they become available. The authors feel that it is especially imperative to make a study of special aptitudes in relation to high intelligence scores. "If", they point out, "peaks of special ability exist in the higher ranges of general intelligence, as they seem to exist in the middle and lower, it is time we were learning how to identify and triangulate them, for the waste in vocationally misplaced intelligence at the higher levels is a far more tragic affair than misplacement at the lower levels. When the potentially skillful mechanic becomes a third-rate salesman, it is unfortunate; if a potential Shakespeare becomes a second-rate scientist, or if a potential Darwin becomes a second-rate poet, the whole world loses."

The authors venture the prediction that before many years test services such as they have been discussing will be installed in all the leading colleges, and may even be extended to include tests of character and personality. They feel that "to predict such a development to-day is less visionary than it would have been twenty years ago to

predict that in the year 1925 school children by the million and college students by the hundred thousand would be given intelligence tests''.

In addition to its research program, the personnel department should aim to be of practical service in the administrative work of the university. ''It must be able to supply, on short notice, significant data needed by the committees on scholarship, admission, registration, vocational guidance, honors courses, graduation, etc. Coöperation with the dean of men and dean of women is definitely implied. The work of the appointment secretary could be made more effective by the use of data available from personnel research. Like the research division of a large industry, the personnel department of a university should, without the handicap of executive or instructional duties, be constantly engaged in testing the materials, processes, and products with which the university is concerned. It must be able to supply many kinds of needed facts regarding student personnel, and a balanced interpretation of those facts, to the committees and administrative officers who can most effectively put them to work.''

Treatment of General Paralysis by Inoculation with Malaria. By Henry A. Bunker, Jr., M.D., and George H. Kirby, M.D. *The Journal of the American Medical Association,* 84:563–68, February 21, 1925.

This is a report on fifty-three cases of general paralysis that were treated by inoculation with tertian malaria. In their preface the authors outline the evolution of this method of treatment, from Wagner von Jauregg's experiments with various fever-producing agents to the present time. They frankly admit that the method is purely empirical, being based upon no known principle. The supposition that the high degree of body temperature produced by the malaria is the chief, if not the sole, factor responsible for the favorable result has against it the fact that, in the case of general paralysis at least, ''the thermal death point of the spirochete is 56 C. continued for ten minutes, although it is stated that the organism fails to grow at temperatures in excess of from 40 to 41 C. (104 to 106 F.)''. On the other hand, Weichbrodt and Jahnel found that ''the complete disappearance and death of spirochetes present in scrotal chancres in rabbits could be brought about by the exposure of animals so infected to temperatures of from 42 to 43 C. (107.6 to 110 F.), provided such exposures were repeated not less than three times. It likewise appears somewhat suggestive that Wagner von Jauregg obtained what would seem to have been progressively better results in

the treatment of general paralysis as he employed increasingly effective febrifacients."

The authors mention as of passing interest in this connection, "the statement of Delgado that from ancient times it has been the custom of Peruvian natives suffering from uta—a leishmaniasis of the skin and mucous membranes—to repair to certain localities where malaria is endemic, the tradition being that after a number of attacks of malaria the lesions of uta cicatrize and are cured". The authors point out that if this is true, "it presents an interesting analogy to the treatment of general paralysis with malaria in the effect of a febrile condition on a protozoal infection".

The question that naturally arises as to the influence of intercurrent infections in syphilitic persons upon the subsequent development or non-development of general paralysis cannot be answered definitely from present data. On the one hand there is the statement of Mattauschek and Pilcz that in a series of 4,134 army officers who acquired syphilis between 1880 and 1900, there was not one among the 195 who subsequently developed general paralysis who gave a history of having had an acute infectious disease, such as malaria, pneumonia, and erysipelas, during the first few years after acquiring syphilis; while of 241 who had an acute infectious disease during that period not one developed general paralysis. But on the other hand there is Kirschbaum's report of ten general paralytic patients who had had malaria during the secondary stage of their syphilis.

The experiment reported in the present paper covered the period from June, 1923, to November, 1924, when the paper was written. The fifty-three patients, all males, who were inoculated were unselected except for the exclusion of far advanced cases and cases in which language difficulties would have seriously interfered with a satisfactory mental examination or the obtaining of an adequate history; otherwise they were transferred to the male service of the Psychiatric Institute as they were admitted to the reception service of Manhattan State Hospital. In all the cases, the diagnosis of general paralysis could be made with reasonable certainty.

After a period of observation, including a weekly record of weight and two or three lumbar punctures, the patients were inoculated intravenously with from 1 to 1.5 c.c. of typed citrated blood obtained from a patient already under treatment. The authors state that they used the intravenous method of inoculation, in preference to the subcutaneous method used in the majority of European clinics, because of the shortened and more uniform duration of the incubation period (from three to seven days as compared to from nine to seventeen days). In order not to complicate the therapeutic picture, the malarial treatment was not followed by the use of arsphenamin.

Each patient was allowed to have between eight and twelve definite febrile attacks, after which the infection was terminated by the administration of 10-grain doses of quinin sulphate three times a day. This quinin medication was in all cases continued over a period of one week, but the drug is so efficient in case of "inoculation malaria" that only three patients had an attack of fever after the first day of its administration.

The authors had the same experience with the atypical and irregular course of inoculation malaria that other writers have noted, the attacks of chills and fever taking place every day far more frequently than every other day. On the other hand, intervals of three or four days sometimes occurred between attacks. In one case there was an interval of six and in another of eleven days between attacks, during which plasmodia were demonstrable in the blood. These intervals were succeeded by paroxysms of greater intensity than before. It was the authors' experience, however, that with successive passages from patient to patient, the course of the infection tended to become more regular.

In view of the theory that the beneficial results of the treatment may be connected with degree of temperature attained during the malarial paroxysms, the authors made a study of maximum temperatures in 470 attacks, temperatures being recorded hourly. In 387, or 82 per cent, of these attacks, the temperature reached 104 F. or higher; in 324, or 69 per cent, 105 F. or higher; and in 223, or 47 per cent, 106 F. or higher. In this matter of temperature, there was a marked difference between the two "strains" of plasmodium—*i.e.*, blood obtained from two cases of tertian malaria—with which the authors have worked, the second strain apparently producing a more intense febrile reaction. This second strain had at the time of writing undergone twenty-two passages from host to host and seemed to show a definite increase in "virulence", if intensity of febrile reaction is a criterion. A comparison of the first eighteen patients inoculated with this strain with the second eighteen shows that in the case of the former a temperature of 106 or above was reached in 33 per cent of their 158 attacks, while in the case of the latter, this degree of temperature was attained in 92 per cent of their 182 attacks.

No serious complications were encountered during the treatment. All the patients showed anemia, from which they recovered within approximately two weeks without treatment, and most of them lost weight; but the authors have reason to believe that this latter symptom may be partly a matter of dietary control. They feel, however, that although hardly to be classed as a complication, "general paralytic convulsions have presented a feature of possible significance in rela-

tion to malarial treatment which . . . seems to lie outside the sphere of coincidence and which at any rate appears to warrant further investigation. Five of the patients treated "entered the hospital with a history of typical general-paralytic seizures, their most recent convulsion having occurred nine days, forty-eight days, fifty-nine days, seventeen months, and twenty-eight months, respectively, prior to inoculation with malaria. Not one of these five patients failed to have at least one convulsion during the actual course of the malaria; or, in one case, within two weeks of the final attack of malaria. Three patients died as a direct result of their seizures; the remaining patients have now survived one month and six months, respectively, without the recurrence of convulsions. On the other hand, two patients who, as far as is known, had never had a general paralytic seizure prior to admission, developed convulsions, one during the course of malaria and the other on the seventh day following the final attack of malaria; two months and three and one-half months, respectively, have now elapsed without the recurrence of seizures."

The authors summarize the clinical results of the treatment as follows:

"Of the fifty-three patients inoculated, eleven have been treated too recently to allow an expression of opinion; two received a course of malaria on two separate occasions; and one failed to acquire the infection after repeated inoculation.

"Of the thirty-nine patients remaining, six died during the actual treatment (five) or within a month of its completion (one) and one died eight months subsequent to treatment after a slight remission of five weeks' duration. Three of the group of six died as a direct result of convulsions; in the case of the other three, death may have been hastened, but was hardly directly caused, by the malaria.

"Of the thirty-two patients now alive at the end of from three to thirteen months from the conclusion of treatment, fourteen are considered as either unimproved or more or less improved (only one of these fourteen is definitely worse), and eighteen are considered as much improved and may be regarded as exhibiting fairly complete remissions, with a residual mental defect, save in the case of perhaps two patients, either undemonstrable or of the slightest possible degree. Seventeen of these patients were discharged from the hospital from one to ten months ago, and fourteen have returned to their former occupations." Of the other three, two, recently paroled, seem fully capable of resuming active work; but the third, a lawyer of standing, still shows minor, but persistent defect symptoms of a mental character that have caused the matter of his reëntering practice to be deferred.

"The outstanding characteristic of the eighteen much improved cases", the authors state, "is the really excellent degree of insight into their previous and present mental condition which, without exception, they exhibit. Less dramatic, but nevertheless well marked, is the improvement in retention, and in the performance of intelligence tests of the Terman type. Memory for recent events regains an acceptable level, although a persisting partial or complete amnesia for some period of the actual psychosis is, as indeed might be expected, not infrequent. A striking feature is the marked sense of well-being which rather the majority of these patients experience—to be distinguished, needless to say, from the morbid elation of the disease itself; some of them state that they have not felt so well for years." The authors do not wish to be understood as implying that these patients are free from residua of any kind; but with the exception of the two cases mentioned, such residua as are exhibited consist almost entirely of "slight defects or abnormalities on the emotional level. At the worst, this may consist of some persistence of emotional instability. The lesser manifestations might be described as in some instances a tendency to mild and transitory depression; in other cases as a certain sobering, so to put it, of the outlook of the individual; and in still others as a diminution of former initiative."

The authors did not find as much improvement in physical signs as they had been led to expect by reports from European clinics. They did, however, observe a rather striking degree of improvement in the ataxia of their three patients with tabo-paralysis. In one the improvement, though definite, was only moderate, "but the other two, from being practically unable to walk in safety without assistance, now get about in a decidedly active manner. Curiously enough, not one of these three patients, all treated more than a year since, has evidenced the slightest degree of mental improvement."

The general finding that there is no parallelism between clinical and serological results in cases treated by inoculation with malaria was borne out by the authors' experience, at least in the sense that patients with definite remissions sometimes showed very little improvement in spinal-fluid findings, while cases in which the spinal fluids became completely negative were entirely stationary and unimproved in a clinical sense. At the same time, there did seem to be a certain degree of correlation between clinical and serological improvement, though the authors admit this correlation may be more apparent than real, owing to the smallness of their groups. On the whole they feel that in many of their cases not enough time has elapsed since the completion of treatment to warrant a conclusion as to serological results. In the case of six patients who received

treatment more than a year ago, serological data obtained at intervals after the completion of the treatment "suggest not only that positive spinal-fluid findings tend to become more or less slowly modified in the course of six months to a year or more subsequent to treatment, but that the cell count is the most quickly and easily affected, and the Wassermann reaction is the most resistant, while the colloidal gold curve becomes very slowly, but eventually modified in the majority of instances, and the globulin, although quickly reduced as a rule, becomes negative only very slowly and in only a certain proportion of cases."

Summing up, the authors state that their results are completely confirmatory of the data already reported and lead to the belief that treatment of general paralysis with malaria is unquestionably a method of value; also, that "the proportion of cases in which the disease appears to be brought to a standstill as judged by clinical criteria, in addition to the proportion in which a striking degree of mental improvement comes about, is in itself not without possible significance".

TRYPARSAMIDE. By H. C. Solomon, M.D. *The Boston Medical and Surgical Journal.* Vol. 191, pp. 1093–94, December, 1924.

Dr. Solomon, of the Boston Psychopathic Hospital, has given here a short summary of medical opinion with regard to the use of the drug tryparsamide in the treatment of neurosyphilis.

"Tryparsamide", Dr. Solomon writes, "is a pentavalent arsenic compound prepared at the Rockefeller Institute of Medical Research in the quest for a drug for the treatment of trypanosomiasis. The reports on its use for this purpose, though few in number, have been of the most encouraging nature, as they suggest that the drug leads to the sterilization of the blood and cerebrospinal fluid in a very short time and produces clinical recovery.

"In 1923, a report was published by Lorenz, Loevenhart, Bleckwenn, and Hodges, on the effect of this drug in the treatment of neurosyphilis. They report both serological and clinical arrest in 100 per cent of the cases of meningovascular syphilis. In the cases of parenchymatous syphilis, including a good many cases of general paresis, they reported 63 per cent arrested and 15 per cent improved. Not only was the effect on the clinical symptomatology interpreted by them as satisfactory, but they also obtained marked improvement in the spinal-fluid findings.

"Some months later, Moore, Robinson, and Keidel reported their results in the treatment of neurosyphilis by tryparsamide and the findings were almost identical with those of their predecessors as re-

gards the spinal-fluid improvement and clinical effects. Results as favorable as these had not been reported previously as following the use of any other drug. Subsequent to the satisfactory results obtained by the two above-mentioned groups of workers, the Rockefeller Institute released the drug to a number of clinics in various parts of the country, including the Psychopathic Hospital and the Massachusetts General Hospital in Boston.

"At the meetings of the American Neurological Association and the American Medical Association in the spring of 1924, several more reports of tryparsamide in the treatment of neurosyphilis were presented, including those of Schwab of St. Louis, Stokes of the Mayo Clinic, Wile of the University of Michigan Clinic, Ebaugh of Philadelphia, Solomon and Viets of Boston, and a second report by Moore. It was practically unanimously agreed that the drug was effective and in many instances gave brilliant clinical and serological recoveries in cases of neurosyphilis.

"Our own personal experience has been quite satisfactory. In many cases of paresis and tabes we have obtained results that seemed quite impressive. Improvement of patients' conditions was frequently observed after treatment with arsphenamine had failed to produce anything that we considered as satisfactory. Of course we have many failures also to report, and we believe that tryparsamide will not entirely displace intraspinal, intracisternal, and intraventricular therapy in the treatment of neurosyphilis, but there seems little doubt but that it will take its place as one of the very important drugs in the treatment of these conditions.

"The work of Moore, Robinson, and Keidel brought out one very important point, namely, that tryparsamide has very little, if any, spirochetal action in early syphilis, and that it was by no means as effective in primary and secondary syphilis as the arsphenamines. They strongly advise against the use of tryparsamide in early syphilis. It is very interesting to contrast the very beneficial results of tryparsamide in the treatment of late syphilis of the nervous system with the unsatisfactory results in the treatment of early generalized syphilis. An explanation of its apparent value in the former group of cases is not readily forthcoming. From the result of chemical analysis, it has been stated that its penetrability into the cerebrospinal fluid is much greater than is that of arsphenamine, which may be one factor in explaining its effects. Another point is that it apparently improves the metabolism, as the patients all gain in weight, as well as developing a feeling of well-being when the drug is given. It may be that a large part of its favorable action is due to raising the general immunity of the patient. There is one very important drawback in the use of the drug and that is its tendency

to produce amblyopia. Like atoxyl, to which it is chemically related, it has a tendency to affect the optic nerve. In from 2 to 5 per cent of the patients given tryparsamide, visual disturbances occur. The majority of these regain their vision when tryparsamide is discontinued. However, in a small number the defect is permanent and in a very few cases the effect may be quite marked. This is a distinct handicap in the use of this preparation and means that it should not be used carelessly, but only with due consideration of the gravity of the condition which one is combating and with the utmost watchfulness to prevent the continued use of the drug when visual symptoms occur.

"A great advantage of the drug is the simplicity of its use. It is an easily soluble powder which does not deteriorate when exposed to the air. It is relatively non-irritating even when given subcutaneously, although its usual mode of administration is intravenously. It causes practically no unpleasant reactions as do the arsphenamines, and when its effects are satisfactory, it obviates the necessity of the more complicated and more uncomfortable subarachnoid injections."

BOOK REVIEWS

DYNAMIC PSYCHOLOGY; AN INTRODUCTION TO MODERN PSYCHOLOGICAL THEORY AND PRACTICE. By Dom Thomas Verner Moore, M.D. Philadelphia: J. B. Lippincott Company, 1924. 444 p.

The author of this useful work is professor of psychology at the Catholic University of America, director of the clinic for mental and nervous diseases at Providence Hospital, Washington, D. C., and, most interesting, a "monk of the Order of St. Benedict". His ecclesiastical affiliations, be it said at the outset, have done little, if anything, to dwarf or distort his point of view; on the contrary, his religious training has enabled him to add to a very excellent equipment in psychology and psychiatry some of the scholarship of the ecclesiastical philosophers and their shrewd intuitive psychology. The more points of view that are taken toward the age-old problems of mind and its disorders, the richer will our knowledge become. It is greatly to Dr. Moore's credit, therefore, that he has enriched the dense stream of psychopathological and psychiatric literature with the pertinent wisdom of the church philosophers, without losing his scientific balance.

Among the objects of his book, as stated in his preface, is an attempt to give the student "a foundation for a practical understanding of his own inner life that will be of assistance to him in the solution of the mental difficulties that continually arise in the course of an ordinary existence". Here again Dr. Moore has succeeded better than have the writers of technical treatises in psychotherapy, on the one hand, and the cheerfully money-making "popularizers" of their works, on the other. He has made his presentation interesting without making it morbid in the process; at the same time, his presentation bears the earmarks of a carefully documented and solidly founded scientific work.

The book is divided into the following parts: *The Analysis of Mind, Stimulus and Response and Human Behavior, Human Emotional Life, The Driving Forces of Human Nature and Their Adjustment, Psychoanalysis and Psychotherapy,* and *Volitional Control.* A word will be said later about the validity of the arrangement of some of these fundamental topics. At this point the reader's attention is invited to the fact that the term "human" appears frequently in the above titles. This illustrates the fact that while Dr. Moore's work contains numerous careful references to work in

comparative psychology, he has not allowed himself to fall into the trap that too zealous behaviorists dig for themselves—that is, he has insisted upon the fundamental differences that exist between human and animal psychology in spite of the many similarities. Under each of the above parts, there are a number of chapters, and the concluding part contains a thought-stimulating critique of the concept of the soul and a useful glossary of technical terms.

The technique of presentation is both historical and critical, and the author does not merely dissect his subject, but synthesizes his discussions with fairness and clarity. The discussion is greatly enriched by citations from the author's own experiences as an experimental psychologist and clinician. The author's philosophical training has enabled him withal to cluster his facts and views about a few fundamental principles.

Dr. Moore has also made a discriminating use of the literature, the roster of names indicating that in his search for the truth he has left no important stone unturned. One meets the names of James, Prince, McDougall, Freud, Jung, Adler, White, Loeb, Jennings, Watson, and so forth, and in addition many names of important contributors to the periodical literature, especially the Germans. In addition Dr. Moore has the rare faculty of being able to summarize in brief compass the views of the masters without thoroughly misunderstanding them, completely distorting their conceptions, or leaving out their very essences. His summaries of the views of Freud, Jung, and Adler, for example, although somewhat too brief, are well rounded. As will appear below, however, it is the reviewer's opinion that much more thought and space might have been devoted to the theories of McDougall. There can be little doubt but that these theories will to a large extent stand or fall on the basis of the rich material of psychopathology; and all experienced workers should inform students of the light thrown on the instinct psychology by the psychiatric clinic.

Dr. Moore appears to have been one of the earliest writers to consider the ethical implications of the psychology of the unconscious. Thus, he asks, "What happens to human responsibility if the mind is subject to unconscious drives?" While his reply is not as convincing and conclusive as he believes it to be, it still furnishes an interesting point of departure in the discussion of this problem. He says: "It is not necessary for us to know why a course of action appeals to us in order to resist it. The sexual drive is strong, but not irresistible. The fact that it masks itself under the temptation to steal does not make it overpowering. The unconscious, by shuffling the cards, makes peculiar and uncanny problems, but not insoluble

ones. We are all subject to pathological associations. No one can render an account of all his likes and dislikes. But it is not necessary in order to behave ourselves with decency and discretion. Something may appeal with a peculiar, indescribable, and inexplicable charm. Analysis of the charm is not necessary in order to see whether or not the course of action it leads to is or is not in accord with the ideals of conduct. The ability to compare action with the standards of conduct is the root of freedom. If we would escape the drive of the unconscious, we must regulate our conduct according to principle. If, however, we follow whims and fancies and thoughtlessly yield to desires, the unconscious bears us along and we know not whither we are going.'' (Pages 27–28. See also pages 392–401.)

This answer leaves unanswered the vexing practical question which one meets with both in ordinary human relations and in the administration of criminal justice: How can we ever tell what impulses are or could have been actually resistible or not? Hadfield's *Psychology and Morals* treats this entire vexing relationship between mental make-up and ethical responsibility in a more satisfactory way, though his treatment, too, leaves much to be desired.

Dr. Moore, in dealing with the various principles of the different schools of psychotherapy, constantly discusses them in the light of his own experience, giving a frank estimate of their validity on the basis of the facts unearthed and the theories suggested by clinical observation and therapeutic practice. This is an excellent method when used with absolute frankness, since it enables others to judge both of the validity of the theories and the practical value of the methods used by the author. At the same time it suggests to other workers in the field further observations and experiments. However, Dr. Moore's scientific honesty and engaging frankness at times lapse into an almost amusing naïveté. Thus he tells us with great seriousness how certain of Freud's ideas have been borne out by his own observations, especially in the field of dream analysis, apparently oblivious of the fact that not a few other psychiatrists have anticipated him in establishing the validity of some of the Freudian constructions. In spite of this, Dr. Moore's illustrative case material from his own practice is in many cases more convincing than Freud's own materials, especially those of *The Interpretation of Dreams*. Teachers of abnormal psychology would therefore do well to look into Dr. Moore's contribution with its teaching value in view. The blunt frankness already mentioned is also apparent when Dr. Moore's experience leads him to disagree with Freud. Thus, his experience convinces him that far from the dream ''regularly'' running back in its essence to the experiences of early childhood, it ''seldom'' does

so; and the usual objection is raised that according to experience all dreams do not "have in them something of a sexual element", Dr. Moore attributing this and other of Freud's faults to an exaggerated tendency to generalize. Nevertheless, it is refreshing to read, after the above criticism, the words of a student of Freud who is above all eminently fair and intellectually honest, when Dr. Moore says that it can be proved "that many dreams that seem free from it [the sexual element] are nevertheless found on analysis to reveal some kind of hidden sexuality". (Page 32.)

Dr. Moore's fairness could be illustrated in many passages, but one more will suffice. Discussing the apparent exceptions to Freud's dogma that all dreams are wish fulfilments, he says: "It may be that Freud is right in referring the dreams that seem to be exemplifications of the inadequacy of his theory to a desire on the part of the patient to prove that his theory is wrong. As a matter of fact, patients do attempt to demonstrate the falsity of the theory when once it has been proposed to them, or at least they will give a dream which is apparently not a wish fulfilment and say: 'There, this shows that the theory is not correct.' " (Page 34.) He then gives illustrations of this typical attitude from his practice.

He offers an interesting theory as an explanation of the sudden change from logical to symbolic thought in the passage from waking to sleeping mental life, which theory he claims does away with the necessity of postulating Freud's "censor". "Perception in waking life, as may be proved by many examples, is the fusion of incoming sensations with past images and categories of experience. In our sleeping life the sensations are largely lacking. Instead, we have a train of thought and the hypnagogic hallucinations [Myer's term for the visual and auditory images which flit before the mind when one is about to fall asleep]. These hypnagogic hallucinations are seized upon by the train of thought, modified by it, and woven into the fabric of our dreams. No censor is necessary." (Page 36.) But one may ask why and how these images are "modified" by the "train of thought". The concept of the censor lends reason and logic to this process, and analysis frequently shows the resultant mental constructions of the somnolent phase of mental life to have had "method" and purpose behind them; they are not haphazard, mechanical, meaningless productions.

Dr. Moore classifies the fundamental forms of mental activity into mental functions or mechanisms by which the forms of awareness are produced, mental products or the "resultant of the activity of the mental functions, the forms of awareness themselves", and mental dispositions, or "traces" that are "left of the change that is wrought

in the psyche as a result of the activity of any of the mental functions''. (Page 43.) While this distinction is more useful in some respects than the traditional tripartite classification into cognition, affection, and conation, since it indicates that these three forms of mental activity do not function in isolation from one another, such a classification has certain pitfalls. For example, it readily leads one to regard the ''traces'' of mental function in too mechanistic a way; indeed, Dr. Moore seems to fall into the *tabula rasa* misconception when he says ''as life proceeds, the tablet of the mind commences to be filled with all sorts of writings''. (Page 45.) For a study entitled *Dynamic Psychology,* this is entirely too static a conception. Nevertheless, Dr. Moore's general point of attack is useful and lends itself nicely to subclassification of an intelligent kind. Thus ''mental functions'' embrace the three classes of reception, construction, and conservation; the group ''mental products'' includes the ''feelings'' and emotions on the one hand, and cognitive functions on the other; and ''mental dispositions'' cover ''general dispositions'', which include temperament and character, and ''special dispositions'' or habits. Having given his classification, Dr. Moore reminds the reader that while the foregoing are ''elements'' of the mind, they are not ''in'' the mind, but themselves constitute the dynamic ''stream'' of mind.

It will be seen from the foregoing classification that Dr. Moore approaches his task with no preconceived narrowness. Neither the methods of objective behaviorism nor the techniques of introspection will discover all of the truth; neither the concept of innate dispositions nor the concept of mechanical, automatic ''stimulus and response'' tells the entire story. The true scientist seeks the facts and uses every known reasonable device to find them.

After the general discussion outlined above, there follows a simple presentation of ''stimulus and response''; but the foregoing has already prepared the reader for behaviorism in its proper setting. Chapters are devoted to ''reflex action'', ''reflex action and reaction-time experiments'', ''tropisms''. Theories of the ''affective mental states'' (''experiences'' would be better) are then discussed historically and critically, and there is an interesting and practical chapter on the ''expression of the emotions'', in which the work of Cannon is analyzed and the James-Lange theory effectively criticized.

Dr. Moore divides affective mental experiences into ''simple feelings'' (''those that arise in response to mere sensations'' and ''those that arise in response to meanings and intellectual insights'') and emotions (''one or more simple feelings along with concepts, sensations, and a more or less complex bodily resonance which is partially

specific and partially common to all emotional states''). Nowhere does the term ''sentiments'' appear, and as to the latter group mentioned above, it seems much more useful and in accord with the facts to divide them into primitive emotions and complex sentiments, after the manner of McDougall.

Dr. Moore appears to put the cart before the horse when he says that ''every human emotional complex has an important element—intellectual insight into the situation that is involved. This insight into the situation is the cause of the emotion.'' (Page 132. See also page 316.) Intellectual insight may increase or decrease an emotion, but it does not ''cause'' the emotion in any real sense of the term. Indeed the presence of an emotion frequently compels us to exercise intellectual insight. It is surprising that a therapist of the experience of Dr. Moore should thus insist upon getting the chain of cause and effect confused. This portion of Dr. Moore's work is in its entirety the poorest. His treatment seems to have broken off the emotional life from the cognitive, or rather superadded it to the latter. He makes the same unsatisfactory treatment of volition, which for some reason best known to himself he puts at the end of his work after having discussed the principal mental mechanisms and devoted considerable space to psychotherapeutic practice. It gives the reader the impression that after Dr. Moore had completed his work, he, like the boy who took the clock apart and then put it together again, had an important wheel left over; so he wrote his chapter on volition. The second portion of the book is not nearly as well organized as the first.

We seriously question also the arrangement of Parts III and IV, the former dealing with the emotions, the latter with ''the driving forces of human nature and their adjustment''. The logical approach seems to us to be to treat of the driving forces of human nature and the emotional life of man together. Nevertheless, this portion contains some valuable criticism of Watson's interpretations of one or two of his famous experiments, such as his scientific observation of the ''behavior of the noddy and sooty tern, that seems on superficial analysis to bear out the concept of the concatenated reflex'' (page 138), but that, on deeper reflection, is shown to be unexplainable on the theory of a complex ''chain reflex''. At this point Dr. Moore's views of behaviorism may be given: ''It is impossible to investigate everything in our mental life by objective methods, for this inner experience is far richer than its manifestations by actions or reactions that can be the objects of an external observer's experience. Nor has Behaviorism been able to attain its goal and predict and control human behavior. A pure Behaviorist would have little place in a

psychological clinic or the schoolroom or the juvenile court, etc. Whenever one wishes to understand any of the real problems of mental conflict, or penetrate into the real causes of the difficulties of life, one has to obtain introspections from the patient in trouble. His reactions alone will not give the insight into his personality that is necessary in order to give him the help he needs. Psychology should enable us to solve the difficulties of the human race as well as to investigate the curve of learning in white rats, dogs, cats, or human organisms." (Page 9.) To this brief, but destructive critique must be added the simple reminder given by Dr. Moore that none of us has as yet been able to perceive the operation of his own mind. "The brain is unknown to those absolutely ignorant of anatomy." No one has as yet felt his "nervous currents". "Neurochemistry is not psychology." These processes may influence conscious life, "but their nature, their character, or anything whatsoever about them, is not given to us among the immediate data of consciousness". (Page 19.) The man who would control human behavior is but little interested in neurological processes or "traces". He is interested in the chief interests of the human family, in what men live for and by, and in how their conduct can be modified and elevated to a higher level; how their loves, their strivings, and their hungers can be squared with socially acceptable conduct; how their perfectly real experiences, their conflicts, can be resolved. In spite of the fact that the technique of Freud, Prince, and other masters is based largely on the birth pangs of introspection, a number of psychologists insist upon categorizing their psychologies as behavioristic, a position in itself requiring a strange sort of purposive introspective rationalization!

According to Dr. Moore, "impulses are the real psychological elements in instincts" and "an impulse is a tendency that we experience, in the presence of an actual opportunity, to make use of any one of our human abilities". (Page 140.) Has Dr. Moore never heard of the excellent advice to "make your own opportunities"? Certainly there are numerous occasions when an instinctive urge manifests itself without the "presence of an actual opportunity". Our impulses do themselves create the opportunities necessary for their expression. Dr. Moore tells us "there are just as many impulses as there are human abilities. Instincts are merely groups of impulses or desires to which popular parlance has given names." (Page 141.) But it is to be regretted that he did not support his statement with a careful analysis of McDougall's facts and theories. Indeed, too many works have appeared, including some ostensibly on "instinct", purporting to dispose of McDougall's views without much ado, but exposing an amazing lack of acquaintance with

that psychologist's own works and a hopeless confusion between the specialized concept "instinct", as McDougall carefully expounds it, and the popular and poetic misuse of the term to denote every faculty, ability, or disability under the sun. Dr. Moore is distinctly not of this class of careless critics; but it appears to the reviewer that in his *Dynamic Psychology,* he could have thrown much more light on the mysterious human dynamo than he has if he had treated McDougall's views with as much care as he devoted to those of Freud, Jung, and Adler.

In other portions of his work Dr. Moore is forced to make use of the instinct concept. "Reflex action, impulse, desire and emotions are at times elements of complexes that we term instinctive reactions. Thus, in defending oneself against danger, there will be an emotion of fear, a desire to flee, impulses to strike, vasomotor reflexes along with the reflex secretion of adrenalin and its effects on the mobilization of sugar, the fuel for muscular action, on muscular tonus, etc. The whole operation of the instinct of self-preservation in this case is a very complex affair." (Page 187.) In spite of this complexity which Dr. Moore stresses it is quite clear that there is an underlying purposiveness, a typicality of phenomena, which he is forced to recognize as a unified, teleological something that he himself calls an instinct.

The book contains a good chapter on desire, the portion dealing with "the management of desires" being especially suggestive; but the entire treatment is weakened by the author's conception of "impulses". There follows a useful chapter on conflict, containing an interesting discussion of the "self-ideal" and of Adler's concept of "organ inferiority" and Meyer's dynamic concept of dementia praecox. "The important lesson that the study of the conflict teaches us is that the undesirable human reactions are dependent on its outcome. The discontented grouch, the sarcastic, the cynical, the psychoneurotic, and the demented are what they are because they have failed. They need not have become what they are. They have mismanaged their lives. . . . They must have guidance now and direction from one who knows better than they. If this is so, the psychologist who would come to their aid should not only understand their type of reaction, but should also be one who has not mismanaged his own life, and has not muddled his own affairs." (Page 181.)

In the following chapter Dr. Moore introduces two new terms, "psychotaxis" and "parataxis". The former he employs "to signify the mental adjustments of individuals to pleasant and unpleasant situations—especially since such reactions often consist in a rearrangement of one's ideas in which some drop below consciousness and

others appear on the surface". (Pages 182–183.) The "positive psychotaxes" are the "tendencies to enjoy pleasant states of mind or to make use of pleasant emotions and feelings"; tendencies to avoid unpleasant situations are "negative psychotaxes". The term psychotaxis is useful to unify that variety of reactive phenomena—defense reactions, compensation, sublimation, and so forth. Psychotaxes are distinguished from rational readjustments, attempts to meet reality squarely, and necessary conscious repressions. These constitute "a directive power that is exercised over impulse . . . not a psychotaxis, but a voluntary effort . . . under the influence of intellectual insight and ideals of conduct". (Page 186.)

Extreme degrees of adjustment to difficulties, abnormal adjustments, as hysterical compulsive seizures in a patient without permanent stigmata of hysteria, Dr. Moore designates parataxes. Upon this basis he discusses in successive chapters the parataxes of depression, of anxiety, of defense, of compensation. Interesting illustrative case material is used throughout.

Part V contains excellent summaries (but all too sketchy critiques) of the work of Freud, Jung, Adler, and Meyer, already alluded to. In this connection Dr. Moore's attempts to employ the term "psychoanalysis" to cover the techniques of those whose methods differ essentially from Freud's should be discouraged. Freud's use of the term is highly specialized and those who have broken away from the school should invent their own terms, not only to avoid confusion in the literature, but in justice to Freud.

Part VI, which deals with volitional control, is an admirable summary of the various theories of the will, including the associationist conceptions, the feelings schools, the kinæsthetic-sensationist concept, the behavioristic view. While this entire part seems to have been written as a sort of afterthought, it is skillfully executed, the author cutting to the root of the difficulties involved in each of the traditional views with a few sharp strokes. Especially useful is the author's marshaling of the evidence in favor of the reality of true volitional power. This discussion illustrates clearly the advantages that psychologists who have also a rich background of psychotherapy possess even in theoretical discussions over academic psychologists. Dr. Moore concludes "that the act of will is a mental element with its own quality, intensity and duration". His treatment of James' ideo-motor theory is convincing. Here his conclusion is that there is no evidence for the first element of James' theory—"that a kinæsthetic image must be the cause of voluntary movement"—and that the universality of the second element—"that the idea of a movement tends to realize itself in action"—has not been demonstrated. (Page 330.) Woodworth's "theory of conceptual control"

(that "a naked thought can perfectly well perform its function of starting the motor machinery in action and determining the point and object of its application") and the work of Watson with infants are then subjected to critical analysis, the author's principal conclusions being the following: "Concepts or thoughts are necessary in the determination of what we are going to do. We cannot perform voluntary acts without knowing what we intend to do. The concept or thought of an action is not sufficient of itself to bring it to execution. The kinæsthetic image does not appear in consciousness in the execution of many voluntary actions. Its value, therefore, is problematical, and demands a further study. Besides the representation of an act there must be a *fiat*, an act of volition which is the final determinant of a voluntary act" and which "produces a neuromuscular coördination which may be maintained for a greater or less length of time in varying degrees of readiness for immediate execution, whenever the *fiat* involves a delay that is to be terminated at the giving of a prearranged signal. . . . The sensations found in passive movement are . . . one element of the voluntary movement sensation complex, even though they may not be essential for the actual execution of the movement. The form of sensation essential to the perception of passive movements is the feeling of stretching that comes to us from the skin and subcutaneous tissues. The form of sensation essential to the voluntary direction of active movements is the feeling of effort. This is a complex which results from vascular reflexes giving rise to various organic sensations from increased blood pressure, and also from sensations coming, in normal individuals, from the muscles and tendons of the moving member." (Pages 342, 367.)

The author's chapter, *The Pathology of Voluntary Action,* is founded on a study of the case material in the files of his clinic. He "tried to study out the various conditions that present a kind of static background for abnormal behavior". To a greater extent than would seem possible, Dr. Moore has apparently succeeded in differentiating such more or less static conditions as inherited constitutional defects from those due to lack of training. This chapter contains a number of interesting case studies. Dr. Moore again makes a difficult, though possible distinction between the following pathological conditions of conation: pathology of voluntary action due to "impairment of the will itself", that due to abnormality of the intellectual life, that due to abnormalities of the affective life, and that due to organic cerebral defect. Interesting discussions of methods of "training the will" and of volitional tests follow.

The study is rounded out philosophically with chapters on the freedom of the will and on the soul. Coming at the conclusion of

a practical discussion of mental mechanisms, mental disorders, and their therapy, these chapters carry with them greater authority than they otherwise would. Discussing the views of James and Ostwald as to the alleged inconsistency of the reality of freedom of will with the physical law of the conservation of energy, and considering the suggestive material of Driesch's great *Science and Philosophy of the Organism,* the author makes no extreme claims from his point of view, but concludes as fairly, in essentials, as he began: "We have no guarantee from philosophy alone that . . . a continuation of existence would, in any sense of the word, be desirable. Philosophy may show that it is inevitable and eternal. Divine revelation alone can guarantee the happiness of eternal life."

SHELDON GLUECK.

Harvard University.

MODERN MARRIAGE. By Paul Popenoe. New York: The Macmillan Company, 1925. 249 p.

This book represents a straightforward attempt by a leading biologist to present the most salient features of marriage as it should be. To say that he has done this with the strictest adherence to truth and with full consideration of present-day needs is but a small measure of the justice due the author even from the most critical reviewer.

No author desires mere platitudes in a careful consideration of his constructive efforts, and so I am inclined to disagree with the selection of the title. Modern marriage seems to consist of most of the things discredited in the book under consideration, and it would seem more appropriate to have called the volume *Ideals of Marriage* or *Normal Marriage,* for modern marriage—with its families of one or two children, its frequent ending in the divorce court, and too often its obvious legitimatizing of intercourse—is certainly what Professor Popenoe is writing against and not about. In the words of one of the philosophers in James Stevens' delightful *The Crock of Gold:* "A sword, a spade, and a thought should never be allowed to rust." This quaint Irish philosophy is most applicable to the work under review. A sword—in fact, a rapier—is constantly kept shining and sharp for repeated thrusts at ancient ideas concerning marriage, and to exterminate much of the old prejudice against biological instruction for those preparing for matrimony. The spade in the hands of Paul Popenoe will never rust, for its use is constant and efficient. Those who should not marry are clearly indicated, as are causes of sterile and unhappy marriages. Last, the thought is constantly in evidence in the careful consideration given such im-

portant topics as the historical background of marriage, the educational period for marriage, and the psychological and physiological aspects of child-bearing.

Modern Marriage is not written for the family doctor (if such still exists) or for the perusal of fond parents of adolescent children, but for young men and women, potential brides and grooms, and so we must inspect the book from their viewpoint. Many persons suffering from inherited and environmental inhibitions, from repressions and conflicts, will be wounded by the sword thrusts, shocked by the use of the spade, and indignant at the clear-cut application of intelligent thought. The wounds will heal, with new tissue sounder than the old; the shocks will produce a wholesome readjustment of cell structure; and the thoughts will bear sound fruit, even though at first repulsed and rejected.

In the appendix we have an account of "my first baby", written by a mother who has most graphic descriptive powers. It is probably the most vivid picture of the pain and glory of motherhood ever written, and should serve to teach prospective mothers the normal process of that crowning achievement of marriage, motherhood.

Modern Marriage might well be read by all between the ages of eighteen and thirty, as well as by many of their elders. Perhaps some of those who have been brought up to believe that knowledge leads to sin will misunderstand this book, but for the few distorted boys and girls who misapply its honest teachings, many more will profit by the straightforward, scientific presentation of a subject absolutely vital to future generations.

Arthur H. Ruggles.

Yale University.

Manual of Psychiatry for the Medical Student and General Practitioner. By Paul E. Bowers. Philadelphia: W. B. Saunders Company, 1924. 355 p.

This volume aims to give a comprehensive and systematic outline of psychiatry and to afford the student and general practitioner a reference handbook of definite, detailed information concerning mental medicine. The author states that he has excluded all controversial discussions and avoided conjecture and supposition in his attempt to give reliable data and conclusions.

The book consists of twenty-five chapters. The first four are of an introductory nature and include definitions, classification of mental diseases—the author using the classification outlined by the American Psychiatric Association and The National Committee for Mental Hygiene—etiology, and symptomatology. The discussion of

"mind", in the first chapter, to include three functions—"intellection or thinking", "emotion or feeling", and "volition or willing"—seems incomplete and apparently the dynamic point of view and some of the recent behavioristic doctrines were not considered. Psychoanalysis is not discussed at all in this chapter. The classification of mental disorders from etiological, psychological, pathological, and clinical viewpoints is in line with modern thought, in that the author emphasizes the need of studying the patient's reactions to social conditions and of attempting to understand the patient instead of merely classifying his disease.

The causes of mental disease, discussed in the third chapter, are summarized in a synoptical table. This chapter, like the following—*Symptoms of Mental Disorder*—allows for considerable individual choice and differentiation regarding the material presented.

For reviewing purposes, we may consider Chapters V to XX, inclusive, as the second portion of the book. This consists of a brief survey of all types of psychoses, discussing definition, etiology, pathology, symptomatology, differential diagnosis, progress, and treatment. The facts given are clear and concise, setting forth the salient features of each reaction type. The chapter on psychoses due to alcohol, drugs, and other exogenous toxins is an unusually good brief discussion of the subject.

The last five chapters, we think, could have better been placed in the first part of the book, particularly those that deal with methods of examination and treatment. The chapter on the relationship of insanity to crime is a valuable addition to the book.

On the whole, the book should prove valuable to medical students. It illustrates the need of standard psychiatric terminology, as well as of a common-sense and dynamic approach to the many problems of mental disorders in place of the older dogmatic, descriptive methods. Incidentally, it is to be regretted that the author employs the unscientific and obsolete term "puerperal insanity".

Franklin G. Ebaugh.

Colorado Psychopathic Hospital.

Clinical Psychiatry. By Edward A. Strecker, M.D., and Franklin G. Ebaugh, M.D. Philadelphia: P. Blakiston's Son and Company, 1925. 375 p.

This book, written, according to the statement on the title page, for students and practitioners, fills a long felt want. There are twelve chapters, dealing first with the approach to mental disease, next with the classification, and then with the descriptive and explanatory content of the psychoses; and at the end of the book is a most useful little glossary. None of the various textbooks published during

the past ten years meets the need of the student of mental medicine as well as this one. The authors have dealt with their material briefly and yet very comprehensively, and some of their case reports are the work of real artists who have produced finished miniatures. Psychiatry is presented here from the point of view that the patient is a human being not only with a brain and spinal cord, but also with a stomach, lungs, and glands of internal secretion, as well as a background that includes both hereditary and environmental factors.

It is refreshing to find a brief textbook of psychiatry that offers so careful a review of all the factors that influence human behavior, and that summarizes findings, treatment, and outcome so clearly. If one looks for faults, they are hard to find. Perhaps the weakest part of the book is the chapter on psychoneuroses and neuroses. This chapter seems a bit curtailed and superficial when compared with the rest of the book. One cannot but wish that the authors had told us a little more about psychogenetic mechanisms and had chosen an illustrative case of anxiety neurosis that had been more thoroughly worked up.

In a word, this is the best classroom textbook of psychiatry yet written. It should be in the library of every physician, nurse, and social worker.

Arthur H. Ruggles.

Yale University.

Essentials of Psychiatry. By George W. Henry, M.D. Baltimore: Williams and Wilkins Company, 1925. 199 p.

There has long been need for a brief textbook on psychiatry. Almost in the same week we are furnished with two—one, the subject of this review; the other, *Clinical Psychiatry* by Strecker and Ebaugh. Dr. Henry's book contains eighteen chapters which cover the modern conceptions of personality development and its relation to the psychoses and psychoneuroses and describe all the principal groups of disorders of the mind. In addition, we have an excellent chapter on principles of treatment, one on psychiatric nursing by Adele Poston, R.N., and others on special precautions and emergencies, psychopathology of the normal, mental hygiene, psychiatric social service, medico-legal aspects, and psychiatric history, as well as a valuable bibliography.

Thus, we have a book that covers a very wide range of material on nervous and mental diseases. The subject matter is brought thoroughly up to date and is most interestingly presented, although the illustrative case material lacks somewhat in conciseness and in its

failure to give complete physical findings. *Essentials of Psychiatry,* in its most stimulating introduction by Dr. Salmon, in its clear approach to the mental processes that underlie mental disease, and in breadth of subject matter, is a real contribution to our psychiatric literature and should have a very wide appeal both as a textbook and for purposes of reference.

Arthur H. Ruggles.

Yale University.

Psychology for Nurses. By Maude B. Muse. Philadelphia: W. B. Saunders Company, 1925. 351 p.

Those who are engaged in the instruction of nurses are frequently asked to suggest books dealing with psychology. Most of such books are too technical, are presented from some special viewpoint, or are not within the range of interest of the average nurse.

It is a source of great satisfaction to find among the new books on this subject one written with the special interest of the nurse in view. This book, whose author is instructor of nursing education at Teachers College, Columbia University, is designed as a textbook and reference book for nurses. Frequent applications of the text are made to actual nursing situations. The whole field of general psychology is presented in a clear, concise, and systematic manner. The author is to be congratulated on the success of her efforts.

It is possible that a more free and serious discussion of the newer dynamic psychology, sometimes referred to as Freudian psychology, might have been of advantage. This would have permitted a closer approximation to the understanding of actual life situations.

The last chapter discusses mental disorders from a psychological viewpoint. It is unfortunate that legal terms such as "sanity" and "insanity" should continue to be used with a medical meaning. As intelligence and reason are minor considerations in functional psychoses, the conception that such disorders are learned bad habits is rather inadequate.

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The Education of Handicapped Children. By J. E. Wallace Wallin. Boston: Houghton Mifflin Company, 1924. 394 p.

One of the results of the enforcement of compulsory education and the child-welfare laws has been the imposing of a new problem upon the public schools. Not only have truant and incorrigible children been made to attend, but also children who are physically or mentally

handicapped. The school must meet this new demand upon it as best it can, and the necessity for devising forms of instruction that will be of real value to the handicapped child has led various educators, doctors, psychologists, and sociologists to make a study of this phase of educational work. Among these Professor Wallin is an eminent contributor to the literature on the subject.

The divisions of material in the book under review show that in the selection of topics the writer had especially in mind the needs of special-class teachers and educators. Professor Wallin has devoted his first chapter to a sketch of four historical epochs in the development of work with handicapped children, dwelling briefly on the contributions of such people as Itard, Séguin, and Montessori. This is followed by a summary of the methods used in training mentally inferior children in institutions and colonies here and abroad.

In concluding the first main division, the author has written an interesting argumentative chapter on theories and definitions. He attempts to answer two questions: (1) Do the feebleminded differ from the normal quantitatively or qualitatively? (2) Is feeblemindedness a simple or a complex condition? The opinions of present-day psychologists on these points are given.

The second sections deals with the questions that confront the public school in relation to the education of handicapped children. The author outlines certain technical requirements which should be observed in the establishment, organization, and conduct of classes for children who are suffering from orthopedic, visual, auditory, speech, conduct, or mental defects.

He makes a special plea that the diagnosis of educationally deviating children be made only by experts. The boundary lines for all groups should be conservatively drawn, on the general principle—which is an axiom at law—that the benefit of the doubt should always be given the child. An attitude of judicious discretion should be cultivated by all examiners and teachers, for hasty decision may result in maladjustment for one whose mental status is uncertain.

The technique of organizing instruction for the mentally inferior and the educationally deficient child presents a large problem to every city. Five various plans for individual assistance are suggested. The author favors centers where work is departmentalized, but also states the advantages of rooms in the regular public grade schools. The attitude of parents is the main objection to a center. However, the aims of a special class are alike whether in centers or separate rooms—namely, to train pupils so that they will attain the maximum degree of self-support and be as slight a burden as possible upon society. The fundamental criterion must be the practical utility

of the subject matter taught. The dominant emphasis must be placed upon practical or vocational rather than upon cultural or academic objectives.

To the special-class teacher or the prospective special-class teacher, the chapters entitled *Efficiency of Instruction* and *Curriculum and the Teacher* will be especially helpful. If superintendents were fortunate enough to secure teachers who possess all the qualities set forth by Professor Wallin, the special class would cease to be a weighty problem.

The final chapters are devoted to a critical consideration of the possible ways in which the mentally defective class may become a positive menace to society. This extends beyond the real purpose of the book, but is well presented.

This book, written as it is from a rich background of experience, will be valuable to all students. Its value is increased by references at the end of each chapter and an appendix at the end of the book.

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Letchworth Village.

MICROBE HUNTERS. By Paul De Kruif. New York: Harcourt, Brace, and Company, 1926. 363 p.

This is a thoroughly delightful book. We have not read all the novels of the winter, but we are willing to take the word of Mr. Heywood Broun that no novel of the year surpasses it in interest or romance. It seems to be generally assumed that the novel is the most recreative form of reading, and it is the novel that finds a place in the suitcase for the week-end or the trunk of a summer holiday; but occasionally a book appears that excels the novel on its own ground of plot and romance. Such a book is De Kruif's *Microbe Hunters*. Another, and an old favorite of ours, is *Pasteur: the History of a Mind* by Émile Duclaux (Saunders). These are books not for the study hour, filled with valuable material though they are, but for the hour before bedtime, the week-end trip, the holiday. There are more real thrills in De Kruif's book than in a shelf of detective stories—and we like detective stories well enough.

In a series of biographical sketches, De Kruif tells the story of the discovery of the world of bacteria, the "little beasties" of Leeuwenhoek, and of the adventures that have taken place since in the routing of superstition and the substitution of knowledge, as the scientist has pressed ever further his investigations into this field. The story is unfolded in major steps, accurately, but with a real sense for the dramatic. For each discovery, and the man who made it, De Kruif briefly, but skillfully builds a background of the time, so that the man

and his work stand out in proper perspective. One lives, for the moment, with the man in his time and in his laboratory; and one comes away with something of the feeling the man himself and his colleagues must have had at the moment the discovery was made.

De Kruif begins his account with Leeuwenhoek, the odd Dutch cobbler, who was "the first of the microbe hunters". The contention over spontaneous generation which came near to setting the Christian world on its head is told in a sketch of Spallanzani who showed that "microbes must have parents". Two chapters are devoted to Pasteur—one an account of Pasteur's demonstration that some of these "little beasties" are a menace, and the other of his study of rabies. In a chapter on Roux and Behring, which is dramatic not alone because De Kruif writes dramatically, but because Roux and Behring were actors in one of the great dramas of time, De Kruif tells of the experiments upon guinea pigs that resulted in the discovery of diphtheria antitoxin. It will be recalled that Sinclair Lewis, in his preface to *Arrowsmith*, gives credit to De Kruif for the scientific material in the book. It will be recalled also that one of the tense moments in the book concerns the decision of Arrowsmith, in the midst of an epidemic, as to whether his new serum shall be used experimentally, or be used with the hope of therapeutic value and the consequent loss of the experiment and the chance to prove beyond question the value of the serum. The scientific background of this incident is found in the life of Roux, and De Kruif tells of it in these words:

". . . Roux looked at the helpless doctors, then at the little lead-colored faces and the hands that picked and clutched at the edges of the covers, the bodies twisting to get a little breath. . . .

"Roux looked at his syringes—did this serum really save life?

"'Yes!' shouted Émile Roux, the human being.

"'I don't know—let us make an experiment', whispered Émile Roux, the searcher for truth.

"'But, to make an experiment, you will have to withhold the serum from at least half of these children—you may not do that.' So said Émile Roux, the man with a heart, and all voices of all despairing parents were joined to the pleading voice of this Émile Roux.

"'True, it is a terrible burden', answered the searcher that was Roux. 'But just because this serum has cured rabbits, I do not *know* it will cure babies . . . and I must know. I must find the truth. Only by comparing the number of children who die, not having been given this serum, with the number who perish, having received it—only so can I ever know.'

"'But if you find out the serum is good, if it turns out from your experiment that the serum really cures—think of your responsibility for the death of those children, those hundreds of babies who did not get the antitoxin!'

"It was a dreadful choice. There was one more argument the searcher that was Roux could have brought against the man of sentiment, for he might have asked: 'If we do not find out surely, by experiment on these babies, the world

may be lulled into the belief it has a perfect remedy for diphtheria—microbe hunters will stop looking for a remedy, and in the years that follow, thousands of children will die who might have been saved if hard scientific searchings had gone on. . . .'

"That would have been the final, the true answer of science to sentiment, but it was not made, and who after all can blame the pitying human heart of Roux for leaving the cruel road that leads to truth? The syringes were ready, the serum welled up into them as he gave a strong pull at the plungers. He began his merciful and maybe life-saving injections, and *every one* of the more than three hundred threatened children who came into the hospital during the next five months received good doses of the diphtheria antitoxin. Praise be, the results were a great vindication for the human Roux, for that summer, the experiment over, he told a congress of eminent medical men and savants from all parts of the world:

" 'The general condition of the children receiving the serum improves rapidly . . . in the wards, there are to be seen hardly any more faces pale and lead-blue . . . instead, the demeanor of the children is lively and gay!' "

Other chapters are devoted to Metchnikoff, who discovered the nature of phagocytes; to Theobald Smith, who demonstrated the relation of ticks to Texas fever; and to Bruce and his work on the tsetse fly. Ross and Grassi divide the chapter on the discovery of the transmission of malaria, and the work of Walter Reed is discussed in relation to the transmission of yellow fever. The book closes with a chapter on Paul Ehrlich and his "magic bullet", salvarsan, which has meant so much to the world as a specific in the treatment of syphilis.

The events of which De Kruif writes were dramatic. The material of drama lay in them because each dealt with an issue of vital importance in the life of man. They were made dramatic because courageous men grappled with these issues, determined to learn the truth at whatever cost to themselves or to the philosophies or sacred superstitions of the day. Equipped with a knowledge of scientific method, and expert particularly in bacteriology, the field in which these battles were fought, De Kruif has been prepared to write of them. His equipment has not been limited to technical knowledge, however, for he has been able to feel the events as well as to know the events—and what medical student has not known of them?—and to put into words both his knowledge and his feeling. The result is a book for every man's library.

Frankwood E. Williams.
The National Committee for Mental Hygiene.

What I Believe. By Bertrand Russell. New York: E. P. Dutton and Company, 1925. 65 p.

In less than a hundred pages the author has given us an outline of his philosophy of life, telling what he thinks "of man's place in the

universe and of his possibilities in the way of achieving a good life''. In *Icarus,* a previous volume, he described his fears; in this book he describes his hopes.

With the progress of science, the physical facts of the universe and even its limitations are becoming comprehensible and correspondingly uninteresting. Since in such scientific fields the author finds no evidence of the existence of God and of immortality, ''the central dogmas of the Christian religion'', he turns to the field of social relationships in his search for a formula of the good life and becomes a scientific moralist, thereby replacing the old-fashioned kind, for which he has great contempt. He deifies man rather than God, believing that man is supreme as the ultimate and irrefutable arbiter of the world of values, and that he debases his kingship if he bows down to Nature—even Nature personified as God.

The good life, then—not necessarily a ''virtuous'' life, but one such as the author would like to live and see others living—is one that is *inspired by love and guided by knowledge.* It is through such a life that the greatest amount of satisfaction for each individual may be obtained, and the evils that result from the ''active malevolence'' in the world may be gradually eliminated. There are many superstitions in the moral field that are preventing our progress toward the realization of the good life. One, an ideal of strict monogamy, is making instinctive happiness impossible. In maintaining such a standard, the clergy are condemning acts which do no harm and condoning acts which do great harm. Other superstitions are seen in the lack of sex instruction to the young and the prejudice against birth control. Finally there are the great superstitions of nationalism and the punishment of criminals.

In view of Bertrand Russell's pessimism regarding existing social situations, his optimism regarding the millenium may seem somewhat extreme. ''There seems scarcely any limit to what could be done in the way of producing a good world, if only men would use science wisely.'' He looks forward to a time when democracy will at last be realized and there will no longer be leaders and followers! However, he admits that the achievement will be a gradual one and that the methods to be utilized are a matter for future science to determine.

With great charm Russell takes us through many lands and ages in the brief space of this little book. If the reader agrees with the author's philosophy, he will devour the book with avidity; if, however, he disagrees with the author, he may find himself stimulated not only to express in an equally positive form his own philosophy of life, but also to seek for an explanation of the underlying reasons for Russell's philosophy, an interesting pastime.

New York City. EDITH R. SPAULDING.

AN OUTLINE OF PSYCHOANALYSIS. Edited by J. S. Van Teslaar. New York: Boni and Liveright, 1924. 383 p.

Van Teslaar has attempted the difficult task of bringing together in a small volume articles representative of the various schools of psychoanalysis, written for the most part by the pioneers. As the result of such an undertaking, we might expect a compact source book in psychoanalysis, an especially valuable introduction for the student of the subject. After a selection of Freud's fundamental contributions, we would then follow, through source selections from the writings of Jung, Adler, and so forth, the various modifications and applications of the original concepts. Such an undertaking would result, however, in a voluminous book consisting of large blocks of material from few sources. It would be of value to the professional student rather than the general reader. For the latter, a book of numerous excerpts, showing especially the wide range and applicability of analysis to various fields of thought, selected on the basis of interest, convincingness, and non-technical language, would be preferable, certainly to the publishers.

If Van Teslaar actually was in this predicament, his choice was a compromise, and we have as a result a miscellaneous selection of articles by fifteen writers, all in 350 pages, some popular, some technical, some devoted to problems of technic, others to first principles, still others to the question of domain. Nevertheless, this volume represents a judicious selection of bits and is a good reference book for students who require a rapid introduction to the major concepts, because it contains Freud's Clark University lectures on the origin and development of psychoanalysis (50 pages), a good statement of Jung's position by Hinkle (*An Introduction to Analytic Psychology*—37 pages), and a very able summary of Adler's concepts by Bjerre (*The Adler Conception of Neurosis*—27 pages). Jelliffe presents his thesis through an illustrative case only too briefly (*Psychopathology and Organic Disease*—8 pages). Stekel is favored with two sections by himself (*The Meaning of Dream Symbolism* and *The Final Results of Psychoanalytic Treatment*) as well as by a eulogy in Van Teslaar's own introduction.

The sections cited are probably to be included under the heading "source material", in as much as each writer presented represents a "school of thought", or, at any rate, a well-known and well-represented point of view. The remaining articles are quite miscellaneous. Putnam's *Personal Impressions of Freud and His Work* is laudatory, defensive, and explanatory and is included purely as a compliment to Professor Putnam's courage and scientific spirit in spite of old age. It is followed by Ferenczi's rather heavy article, *Stages in the Development of the Sense of Reality,* a distinctly technical contribu-

tion. Brill is represented by his chapter on the only or favorite child in adult life, an article primarily clinical and statistical, showing the end results of an analytic investigation and in this respect differing from the rest. Pfister contributes to the volume *The Domain of Pedanalysis* and a discussion of the whole question of lay versus medical analysts. Since Pfister himself is a minister and a lay analyst, he makes out a strong case for the school-teacher-analyst, though it is difficult to see why this particular problem should be included in an outline. Rivers comes in with a chapter on psychology and politics—a companion piece to Pfister's, probably—showing the application of analysis to the fields of education and politics. Emanuel contributes an interesting clinical chat in his *Anagogic Psychoanalysis.* Van Teslaar ends the volume with an historical-philosophical article, *The Significance of Psychoanalysis in the History of Science.*

This review is limited to a consideration of the matter of selection. It will be seen from the headings cited that the book needs better weighting, more elimination of extraneous or repetitive material, and larger sections from fewer sources. We are still waiting for a satisfactory source book on psychoanalysis.

David M. Levy.

University of Chicago.

Psychotherapy; Mental Elements in the Treatment of Disease. By Edward Wyllys Taylor, M.D. (Harvard Health Talks, No. 14.) Cambridge: Harvard University Press, 1926. 53 p.

This is the latest of the valuable series of "health talks" being issued in convenient and inexpensive form by the Harvard University Press. Other books in the series, each a public lecture delivered at the Harvard Medical School by a member of the faculty, are *The Care of Children,* by John Lovett Morse; *How to Avoid Infection,* by Charles V. Chapin; *New Growths and Cancer,* by Simon B. Wolbach; *The Causes of Heart Failure,* by William H. Robey; and *A Present-day Conception of Mental Disorders,* by C. Macfie Campbell.

Dr. Taylor's book sketches briefly and clearly the steps in the development of psychotherapy. He divides the periods into (1) preceding the eighteenth century—miracles, mysticism, domination of the church; (2) eighteenth century—charlatanism: mesmeric and animal magnetism; (3) beginnings of scientific method—Braid (1842), hypnotism; (4) clinical period—Charcot (1878), hysteria, Janet; (5) analytical school—Freud, Jung. Each period is discussed briefly and its relation to what has preceded is shown. In discussing the present approach to mental problems, through psychoanalysis, no attempt is made at a detailed exposition, as such exposition would

have been clearly beyond the intent of the lecture, but a clear statement is made of the major hypothesis upon which the work of the psychoanalysts rests, and the author concludes by saying: "The time has certainly come, and our knowledge, imperfect as it is, is sufficient to accept the broader implications of treatment which a rational psychotherapy permits. Again, I emphasize the word 'rational', since we have finally attained knowledge in this difficult, but most important field of research, which every well-trained physician must in some degree master, if, as he should, he sets himself the task of treating disease by all legitimate methods."

FRANKWOOD E. WILLIAMS.
The National Committee for Mental Hygiene.

THE MEANING OF DREAMS. By Robert Graves. New York: Greenberg Publisher, 1925. 167 p.

The attitude of the author of this book towards psychoanalysis appears in the following quotation (pages 11–12): "Freud's position is briefly this, that every dream is expressing some sort of desire which the dreamer in his waking life has not been able to attain and, more than that, has not even claimed to consider, because somehow horrible or unnatural or very strongly disapproved of by the neighborhood. These wishes are centered in the passions, and in order to account for children dreaming, Freud has been forced to say that even very small children are subject to the same inclinations and passions as grown persons; it is this theory that has given Freud most ill fame and frightened away the common-sense man more than ever from the subject, particularly as the Freudian theory soon attracted to Vienna a number of students who liked nastiness for its own sake, so that the work which they did on the lines the professor laid down had nastiness as its chief aim."

With such an attitude of resistance toward psychoanalysis, there can be expected only the most superficial analysis of dreams. There is nothing in the book which shows that the author clearly comprehends the phases of libido and ego development, of the meta-psychological interpretation of dreams, of the mechanism of nightmares, or of the fact that dreams are the distortion of pre-conscious material by unconscious mechanisms. The book is a mixture of limited insight and severe resistances. The author criticizes Bergson's superficial theory of the peripheral origin of dreams, but on the other hand he hopes that his readers, after reading this volume, will be able to interpret their dreams for themselves. What about the resistances of auto-analysis?

The whole question of transference when the infantile past is

reanimated in the analysis is poorly grasped. There is no difference between the dreams of light sleep and of deep sleep, as is claimed, neither are the association tests used for dream analysis. The best chapter is that on dreams and poetry, particularly the marshaling of the material unconsciously used by Coleridge in the composition of *Kubla Khan,* done in much the same manner as that in which Amy Lowell has traced out the sources of Keats' famous sonnet, *On First Looking into Chapman's Homer.*

Isador H. Coriat.

Boston, Massachusetts.

The Nervous Patient. By Milais Culpin, M.D. London: H. K. Lewis and Company, 1924. 305 p.

This book, from the pen of a British physician, is another effort to elucidate to general practitioners the frequency of nervous disorders among their patients. The effort is to be commended, but the result cannot be wholeheartedly praised. Dr. Culpin has adopted a new classification of the psychoneuroses, but one that offers nothing definitely constructive and that is open to the very criticism that he makes of the older classifications. He abandons the term psychasthenia, he admits, with some reluctance, but retains neurasthenia, attempting to compensate for this by dressing it up with the addition of "actual", hardly a convincing gesture of nomenclature.

The description of the psychoneuroses and psychoses is attempted under the headings *Minor Psychoses* and *Major Psychoses,* to our mind a sound and broad conception of the fact that most of the psychoneuroses are not "nervous breakdowns" at all, but in reality disturbances of the psyche, and that the sooner we all understand this, the better treatment the patient is likely to receive.

Throughout the book we find instances of the author's lack of familiarity with the latest medical and psychiatric literature, as indicated by his observations on the medical and surgical treatment of goiter, as well as by the statement that we are without knowledge as to the cause of hypertrophy of the thyroid gland and, again, by his casual remarks on the loss of the sense of reality.

One chapter deals with exophthalmic goiter, stammering, epilepsy, and hysterical fits—rather a large order, considering our knowledge of the varying mechanisms underlying these conditions and the necessarily diverse technique of therapeutic approach.

Such a positive statement as, "Visceroptosis, with all its gross pathological sequelæ, arises through lack of muscular tone and is dependent upon a mental state", hardly commands the unqualified respect of the clear-thinking medical man and leads to the feeling that the author has often overstepped the bounds of scientific facts in attempting to

uphold his thesis. Applying the methods of analytic technique, I am led to the conclusion that Dr. Culpin, who states that he was doing surgery at the time of the Great War, has overcompensated for some of the inadequacies of surgery in his desire to prove the psyche the origin of most human ills, and that when he has dealt somewhat longer with the "nervous patient", he will incline to a broader and more scientific psycho-biological treatment of his subject.

This book contains a chapter on eye symptoms by Dr. W. S. Inman. Here we have a useful warning to the ophthalmologist against forgetting that his patient has emotions as well as eyes, and a clear demonstration that the indiscriminate use of glasses for minor visual defects may not bring the desired cure unless the mental life of the individual is also corrected.

Dr. C. Stanford Read contributes *The Major Psychoses in General Practice.* This is a clear-cut, frank, and forward-looking chapter which should impress upon the general practitioner the need of early recognition and understanding of the symptoms of mental disease. Dr. Read's contribution should be called to the attention of all general practitioners as it constitutes a valuable addition to our flood of mental-hygiene literature.

In conclusion (I almost said, *in memoriam*) *The Nervous Patient,* as presented by Dr. Culpin, challenges all non-psychiatric doctors to a psychiatric point of view toward their patients, but hardly clarifies the problem from the point of view of scientific approach. We praise the attempt, but believe that the author, after further investigation and wider reading, can in the future make a more valuable contribution to this important subject. It is to be hoped that he will, at all times, include the work of Dr. Read with his own.

Arthur H. Ruggles.

Yale University.

The Sexual Life. By C. W. Malchow, M.D. St. Louis: C. V. Mosby Company, 1923. 317 p.

This book, which has passed through six editions, was written before 1907 and bears the distinctive imprint of the discursive, descriptive sexology of Havelock Ellis and Krafft-Ebing. Having consigned it to this class, one may say that it deserves to rank with the best of its type. The well-established medical facts of sex hygiene are stated clearly and in the main accurately, the physiological data are impassively detailed, and innumerable quotations on questions of hygiene and morality are cited from a wide range of authors, from Hippocrates to Freud (one of his earlier works), from Plato to Marion Crawford. Throughout the book Dr. Malchow sustains a note of

sincerity and dignity and manages to convey a spirit of genuine insight into and sympathy with the struggles encountered in normal and even some of the intricate phases of abnormal sexual life. His advice is generally sound and reassuring and in many instances the close interrelationship between sexual irregularity and disordered functioning of other organs of the body is convincingly presented.

C. P. Oberndorf.

New York City.

Child Marriages. By Mary E. Richmond and Fred S. Hall. New York: The Russell Sage Foundation, 1925. 159 p.

The authors of *Child Marriages* remark that Americans still have a romantic idea that there is something peculiarly idyllic about child marriage, and then proceed to cite case after case wherein the romance vanishes on nearer view. In the chapter entitled *Married Children* data are set forth showing that out of ninety cases only sixteen married pairs were still living together. At this rate no high level of stability in home life seems possible.

Prepared as a part of a country-wide study of the administration of marriage laws carried on for several years by the Russell Sage Foundation, this section furnished so many unsuspected facts regarding child marriage that it was printed in advance of the larger work. The study was carefully and scientifically made, based on actual social research into the laws and their administration. Investigators visited ninety cities in twenty-eight states, securing firsthand material from records and license issuers and supplementing their findings with all available statistics. This resulted in the collection of certain surprising facts: Approximately 343,000 women and girls began their married life as child brides within the last thirty-six years. In fourteen states the minimum marriageable age is only twelve for girls; in nine states, it is fourteen years. Native white girls contracted almost as many youthful marriages as foreign-born white girls—13.3 per cent as opposed to 14.3 per cent, and first generation native white girls of foreign parents only 6 per cent.

The last chapter contains in brief a definite, practical program of reform. *Child Marriages* will doubtless become a handbook for a very important phase of preventive social work.

Kathleen Ormsby.

The National Committee for Mental Hygiene.

Outlines of Introductory Sociology. By C. M. Case. New York: Harcourt, Brace, and Company, 1924. 980 p.

This book, as might be guessed from the modest title, is a substantial volume, showing wide scholarship. It is another attempt to

solve, by means of well-selected readings, the unsolved problem of the first course in sociology. It covers the ground acceptably, though its treatment of the material in certain of its sections is inevitably very sketchy, and one questions whether it would not have been wiser to devote more attention to the strictly sociological fields and leave entirely to another course the social-economic problems.

Case's own approach is neither biological nor psychological, but cultural. Culture for him is the true domain of the sociologist, into which psychology and biology can shed light, but which they are inadequate in method and insight to explain or master. The field of social attitudes (social psychology) is, however, represented by extracts from Thomas, whose suggestive, but overworked and abused "four wishes" he also accepts. (Thomas' "Hegelian ladder" of attitudes and values should be compared with Healy's recent "circular-response" theory.) The sociological conception of the *person,* as contrasted with the psychic individual, is well developed.

In relegating psychology to innate qualities and implying that culture and psyche are independent universes of discourse, Case apparently accepts the very difficult position assumed by the American ethnologists (Kroeber, Lowie, *et al.*) as the only alternative to the impossible assumptions of the eugenists. It seems to the reviewer that it should be possible to reject the omnipotence of an all-inclusive Heredity without setting up an equally mystic independent entity, Culture.

The civilized educational process, in its aspect as the transmission of social heritage, is represented by the exceptionally constructive essay, *The Unprintable Textbook,* by J. K. Hart.

The physio-biologic basis of personality is recognized. One wishes that Kempf or other better recognized psychopathologists had been quoted in this connection. The possible contributions of psychiatry to social theory are hardly recognized.

Mental hygiene is represented by extracts from Healy, Bronner, and White, and what is now known as "the psychiatric attitude" is well described by Mead in an extract dating from 1918. The discussion of mental hygiene is limited, however, to children and criminals. The cultural basis of crime is well recognized. Defectives are treated as a eugenic problem.

Those who affect to sniff at sociology would do well to read a book of this sort, in which its limitations and its immaturity are frankly faced, but in which the study of its materials (social attitudes, cultural values) is shown to be useful, even indispensable, to the understanding of human behavior. Sociology used to be social

philosophy. At present it "ain't what it used to be", and those who had their sociology ten or twenty years ago cannot afford not to catch up with it.

Occasional bad spelling and proof reading mar an otherwise excellent publication.

THOMAS D. ELIOT.

Northwestern University.

FIVE PAPERS BEARING UPON THE SIGNIFICANCE OF SCAPULAR TYPES IN RELATION TO INDIVIDUAL LIFE ADAPTABILITY AND FITNESS.* By William W. Graves, M.D.

In lucid and interesting style, Dr. Graves, professor of neuropsychiatry at the St. Louis University, presents, in this series of papers, the findings and conclusions reached by him in his very thorough and extended studies of the human scapula or shoulder blade. A chief concern in this investigation, it seems, is the possible significance of the anatomic character of this bone in relation to the general question of mental and physical adequacy—that is, as an index, so to speak, of biologic fitness. The work takes on a very special interest at this particular time, lending added significance to recent contributions in the field of human constitution, notably by such workers as Kretschmer and Draper. According to these students, as is known, there would seem to exist a very real relationship between anatomic characteristics and individual make-up, even to the point of susceptibility to actual disease, both mental and physical. This angle of approach, obviously, is most fundamental and helpful to the proper biologic envisagement of human problems, emphasizing as it does the "total" nature of individual organization and response, and stressing the rôle of the host, as such, in relation to health and disease, to adaptation and maladaptation in the broadest sense.

Graves classifies scapulæ, anatomically, into two groups, the convex and the scaphoid. Scapulæ with concave or straight vertebral borders are designated as scaphoid, in contrast to the convex, in which the

* 1. *The Types of Scapulæ.* American Journal of Physical Anthropology, Vol. 4, pp. 111–28, 1924.

2. *The Age Incidence of Scapular Types; Its Possible Relation to Longevity.* Address before the Association of Life Insurance Medical Directors, 1924. 31 p.

3. *The Relations of Scapular Types to Problems of Human Heredity, Longevity, Morbidity, and Adaptability in General.* Archives of Internal Medicine, Vol. 34, pp. 1–26, July, 1924.

4. *Methods of Recognizing Scapular Types in Living.* Archives of Internal Medicine, Vol. 36, pp. 51–61, July, 1925.

5. *The Relations of Shoulder Blade Types to Problems of Mental and Physical Adaptability.* London and Edinburgh: Oliver and Boyd, 1925. 35 p.

vertebral border is outwardly rounded. While showing a tendency to vary with age, these types may, according to Graves, nevertheless be regarded in general as representing "innate" characteristics, transmissible from generation to generation.

Careful analyses of large contrast series of biologically adequate and inadequate types—and herein lies the crux of the author's thesis—show very striking differences from the standpoint of the comparative incidence of these two scapular forms. Thus, of a series of 233 medical students ranging in age from twenty to thirty years, 52.8 per cent were found to possess shoulder blades of the scaphoid types and 47.2 per cent of the convex form. Similarly, in 52 per cent of 867 army applicants—presumably an average group with an age range of twenty to thirty-five—the scaphoid type was noted, and in 47.3 per cent the convex.

However, in a series of 233 feebleminded persons (age range twenty-one to thirty) the incidence of the scaphoid type of shoulder blade was 73.9 per cent and the convex only 26.1 per cent. And in a series of 381 prisoners (age range twenty to forty) the scaphoid form was found in 79 per cent and the convex in but 21 per cent. Likewise, scaphoid scapulæ represented 77.6 per cent of the total among 250 insane patients, ranging in age from twenty to thirty, and 82 per cent for a series of 270 prostitutes (age range twenty to thirty-four). Of interest also was the finding of a scaphoid incidence of 73 per cent as opposed to 50.5 per cent in large groups of tuberculous and non-tuberculous soldiers, respectively, of similar age distribution.

Of course, as is immediately apparent, certain of these groups are rather loosely conceived, representing at best but uncertain and somewhat heterogeneous categories. Nevertheless, it is equally apparent that very striking differences do obtain, indicating on the whole a predominance of the scaphoid type of scapula in individuals of inferior type, whether the specific basis of classification be physical, mental, or social.

The author also feels a greater longevity may be expected in persons with convex scapulæ, explaining in this manner the striking preponderance found for this type in the later stadia of life. This relation, as can readily be seen, is quite compatible with the demonstrated predominance of the scaphoid type in those of defective organization.

In conclusion, this work of Dr. Graves impresses the reviewer as extremely interesting and certainly deserving of really serious consideration. To the reader, the fifth paper of the series is especially recommended. This is a brochure of 35 pages, representing the text

of the Fourth Henderson Lecture, delivered by the author at Edinburgh in October, 1925. It is very complete in its treatment of the subject, yet entirely simple and untechnical and, it seems, may be secured from the publishers at the nominal cost of sixpence.

THEOPHILE RAPHAEL.

State Psychopathic Hospital,
Ann Arbor, Michigan.

THE CONSTITUTIONAL FACTORS IN DEMENTIA PRAECOX, WITH PARTICULAR ATTENTION TO THE CIRCULATORY SYSTEM AND TO SOME OF THE ENDOCRINE GLANDS. By Nolan D. C. Lewis, M.D. (Nervous and Mental Disease Monograph Series No. 35.) New York: Nervous and Mental Disease Publishing Company, 1923. 134 p.

This work of Lewis' deals with certain constitutional factors in dementia praecox considered from post-mortem material. The basis of the work is a review of the autopsy material that has accrued at St. Elizabeths Hospital since 1884. From approximately 4,400 autopsies Lewis selected 601 cases in which the diagnosis of hebephrenic or catatonic dementia praecox seemed fairly certain. The report divides itself naturally into two parts, the first dealing with the organization of the cardio-vascular system, and the second with the endocrine glands.

His observation in regard to the cardio-vascular system in cases of hebephrenic and catatonic dementia praecox is that the hearts and aortæ are on the whole smaller than in the normal individual. Thus, of 601 cases he finds 430, or 71 per cent, in which the hearts were below the average weight as given in various statistical tables, while in 171 cases, or 29 per cent, they were equal to or greater than average weight. Further, he finds that in 204 cases, or 33 per cent, the aortæ were small or, as he calls it, "aplastic"; in 136 cases, or 25 per cent, the aortæ were diseased; while in 261 cases, or 39 per cent, they were normal. He finds that even the small vessels in the cases of dementia praecox were smaller than the average and of defective histological make-up. Lewis takes into consideration the fact that " chronic exhausting diseases produce some atrophy of the heart muscle, thus causing general diminution in size and loss in weight, but here the pathological differentiation between atrophy and aplasia is not difficult, and one also has the size and condition of the aorta and its branches as additional aids". He also considers the high incidence of tuberculosis in dementia-praecox patients, but he accepts neither the theory that tuberculosis may account for the small hearts, nor that tuberculosis is the cause of dementia praecox; on the contrary,

he feels that the condition of the cardio-vascular system, with the relatively small-sized pulmonary vessels accompanied by the large lymphatic vessels, leads to lymphatic stasis and thus predisposes to tuberculosis. So he theorizes that tuberculosis and cyanois of the extremities are dependent on the constitutional deficiencies of the cardio-vascular system, and, as his observations lead him to believe that this is a common characteristic of dementia praecox, that these other conditions should necessarily be concomitants of the latter disease.

Lewis further states that not only do the hearts and aortæ tend to be small in size, but that the structure differs from the normal. Thus the cardiac muscle is deficient and does not have the normal power of hypertrophy when valvular lesions occur. He thinks that in these cases the hearts do not appreciably enlarge with age as is characteristic of the normal individual. He finds that "the walls of the congenitally small aortæ are thin, smooth, free from lesions, except occasionally in the very aged (when they are less extensive than expected), and usually hyperelastic".

He thinks it noteworthy that the blood vessels are relatively free from atheromatous changes, and suggests that the inadequate circulatory system is an hereditary factor. He says, "It is just this type of inherited constitution, the inadequate, underdeveloped circulatory system and the deficient 'tissue stuff' composing some of the endocrine glands, and, allowing for early aplasias, multiple glandular scleroses, and dysfunction, which renders an individual in danger of developing the 'praecox' psychosis at puberty, or if then escaped, at some subsequent period of more severe physical, chemical, psychic, or social stress."

The other division of Lewis' work deals with the endocrine glands. In this latter study he uses a comparatively small number of cases. He reports that in 16 of 19 males he found gross testicular changes, and microscopic changes in 10. Out of 22 cases he found 15 with renal glands which he considered grossly atrophied, 5 in which they were of average size, and 2 in which they were larger than average. Microscopic investigation of 11 cases convinced him that there was an arrest or regression in the cortex of the adrenals. Of the 21 thyroid glands examined, he thought that 7 were unusually small, 9 smaller than average, and 5 unusually large. The combination of the changes in the endocrine glands and the small cardio-vascular system Lewis takes as an indication of a constitutional factor in hebephrenic and catatonic dementia praecox. He believes that this condition is not found in paranoid dementia-praecox cases, and he considers the latter as quite different from and not belonging to the same group as the other two types.

Interestingly enough, he has noticed that the cardio-vascular system in cases of general paresis is also smaller than the average, and he promises a discussion of this finding in the future.

In his conclusion he warns that "the knowledge of the presence of these fundamental organic peculiarities composing the soil in which the disordered mental habits arise should in no way interfere with the dynamic conceptions of the mental disease nor discourage the all-important studies on mental mechanisms".

Lewis has given some interesting tables in this monograph to show the basis of his deductions. Eighty-six pages of the 134 are devoted to case histories. There are some very instructive photographs and photomicrographs which help greatly to illustrate his concepts.

It is always a bit presumptuous to discuss and criticize work that one has not attempted to repeat oneself. However, as the author has invited a discussion of his presentation, a few words may not be altogether out of place. His work on the cardio-vascular status of his cases is extremely suggestive. One regrets that he did not record the other measurements of his patients in addition to those of the heart. It would be very much more convincing if one knew that the cases were of average size with hearts below the average. However, considering the amount of material, one may assume with Lewis that the majority of his patients could not have been undersized. Whatever the explanation of the relatively small aortæ, the observation, if corroborated by future investigation, means a great addition to our knowledge of some of the schizophrenic group, and will add to the interest in the study of the constitutional factors in dementia praecox. This interest has already been stimulated by the works of Kretschmer, Gibbs, and others.

One is inclined to view with more skepticism the author's conclusions with regard to the endocrine system. The number of cases in which the endocrine glands have been studied is comparatively small, and so little is known of the normal histological characteristics of these glands in various conditions of health and disease that any far-reaching conclusions would seem a bit premature. The work of Mott, to which Lewis refers, has been criticized by a number of investigators, and the same criticisms may be applied to the observations of Lewis. It should be remembered that the observations, if true, and the conclusions drawn therefrom should not militate against the study of the psychological mechanisms underlying the psychoses. The book is a distinct contribution to the literature on the bodily make-up of schizophrenic patients and is worthy of study by all interested in this field.

CLINICAL PSYCHOLOGY. By Louis Edward Bisch, M.D. Baltimore: Williams and Wilkins Company, 1925. 346 p.

Bisch's task—writing a guide to teachers—is not a simple one. His attempt to adapt his book to more general use makes the problem even harder. Any one who has struggled with the job of making a useful presentation to teachers realizes the importance of orientation, foundation, and limitation of the matter presented.

After an historical sketch, limited to mental deficiency, the student is plunged into a detailed examination devolving on one or another expert examiner—psychologist, social worker, psychiatrist, and so forth. The culmination of this is a summarization of positive data and the formulation of a diagnosis, which the author considers necessary in order to crystallize the case. Prognosis and treatment follow, but their relationship to diagnosis is not explained, nor is it shown how the data obtained are converted into diagnosis, prognosis, or treatment. The chapter on classification is quite complete, including major and minor psychoses and neuroses, but again the key for relating this to the results of examinations is not apparent. Chapters on normality, precocity, retardation, and amentia follow. The author takes up a discussion of major and minor psychoses, epilepsy, and personality deviations, with special emphasis on their relations to childhood problems. A chapter on syphilis is inserted with the aim of clearing away the misconceptions that too often arise. Heredity is given special emphasis as a cause of congenital amentia, and the various tests now used to estimate mentality are described. In the chapter on treatment certain radical or irrational lay conceptions are dealt with. Finally the relation of psychological problems to social problems is discussed.

Fifty-eight cases, examples of clinical psychological problems, contribute a good deal to the usefulness of the book. Notes explaining the derivation of the classification of these cases would have unified the book better and made the earlier chapters more significant. The illustrations in the book showing mental precocity, dementia praecox, psychoneurosis, epilepsies, and congenital syphilis might tend to produce misconceptions of the clinical psychologist's power of diagnosis from observation. One feels the need in this book of pre-clinical chapters orienting the reader physiologically and, in particular, psychologically.

GEORGE S. STEVENSON.

University of Minnesota.

THE NATURE OF LOVE. By Emanuel Berl. Translated by Fred Rothwell. New York: The Macmillan Company, 1924. 278 p.

The nature of love! What a subject! How universal the audience for such a title! One may picture the ever-seeking scenario writer reaching hopefully for a copy of Mr. Berl's book. But would he go beyond the index, with its first and second inquiries, chapters on realistic, idealistic, biological, and sociological explanations, its pluralism, monism, dynamism, intuition, and fusion? Probably not. Yet he, and many other readers, will be mistaken if they read only the index. The book is essentially scholarly; unfortunately it reminds one of the thesis for a doctorate. Abundant, precise, impartial restatement of existing material on the subject of love constitutes Part One. Well done, but rather tiring, though the crisp section on ascesis is priceless for quoting to such friends and relatives as greedily grasp each opportunity to "renounce".

But in Book II, the author adds himself to his material and excellent style, and there comes warmth. By all means, first read the second part. It is even worth thinking about, too.

Mr. Berl, though not himself a Roman Catholic, finds it "less difficult to picture to oneself this fusion of the self and the not-self by considering religious feeling than by considering sexual love". His most sympathetic discussion of love is in the experience of ecstasy by the mystic. He says love is a conjunction, "a kind of sympathetic power of reality. . . . The Love of God for God, the love of God for man, the love of man for God, and the love of man for man are in reality only one and the same thing, the fourfold aspect of one and the same reality. . . . Love is not simply a contemplation that knows, or a will which, though still blind, grows and develops. It is that which unites, the creator of couples, of families, of states, of churches—the bond of union everywhere."

After reading this careful discussion of love, its causes, attributes, and qualities, its jealousies and chivalries, will the casual reader be able to offer a better definition of love?

And yet, to quote Mr. Berl once more, "We can neither think nor speak of love without distorting it. Though what we say of it be true, love is nevertheless something different from what we say of it."

EUNICE B. ARMSTRONG.

Scarborough-on-Hudson, New York.

CONTROLLED POWER: A STUDY OF LAZINESS AND ACHIEVEMENT. By Arthur Holmes. Boston: Little, Brown, and Company, 1924. 219 p.

In reading the first few chapters of this book, the thought occurred to the reviewer that here was another addition to uplift literature—

The Power to Achieve, The Key to Success, Increase Your Brain Power, Others Have Done It, Why Not You? and so forth. The neat little verses sandwiched in at appropriate intervals added to this irritation. The disagreeable impression, however, was short-lived. With the conclusion of the work came the realization that most of it had been really enjoyable reading.

The book was written for a definite purpose and the style is suited to that end. Dr. Holmes has presented much helpful information in a popular way. This is a double achievement. He has taken the materials commonly used by the advocates of "will power" as the determining factor in life and has given these materials their proper interpretation. Holding before the boy of school age the lives and achievements of Edison, Roosevelt, Lincoln, Napoleon, and Caesar may have its value as a stimulant, or spur, to better effort. But many ambitious and conscientious youths have been materially damaged by being told that they could be as great as any of these men if they would exercise their "will power" and persevere.

When an average person tries to run his life on as little sleep as Mr. Edison requires, he generally runs into difficulties. His constitution is not built that way. Some geniuses have been able to work for long hours and for long periods of time without recreation or diversion. But when the average college student attempts to follow so exacting a schedule, his health will not stand it, and he is injured in body and mind before he realizes his mistake.

Dr. Holmes has treated the subject of genius in a common-sense and helpful manner. His book comes at a time when an antidote for overwork and over-reaching ambition is greatly needed. It gives the reader a solid foundation upon which to build an understanding of himself and of those with whom he has to work.

The book is a unit. It is to be read as a whole. Each chapter is necessary to its completeness. As one reads through the first few chapters the question arises, "What about the lazy youth who is physically sick?" This question is satisfactorily dealt with and elucidated before the conclusion is reached.

Dr. Holmes' style is facile and untechnical. His psychology is sound. He has made available to the lay mind information that heretofore was to be obtained only through a technical training in psychology and physiology.

W. P. McElroy.

Boston Psychopathic Hospital.

THE PRIMITIVE ARCHAIC FORMS OF INNER EXPERIENCES AND THOUGHT IN SCHIZOPHRENIA. By Alfred Storch. Translated by Clara Willard. (Nervous and Mental Disease Monograph Series No. 36.) Washington, D. C.: Nervous and Mental Disease Publishing Company, 1924. 106 p.

This monograph is a genetic and clinical study of schizophrenia, an examination of the relations between the inner experiences and thought life of present-day dementia-praecox patients and those same processes in primitive man as reported by investigators in the fields of ethnology, genetic psychology, and religious history. The author reminds us that this relationship was recognized long before the advent of psychoanalysis, and quotes particularly the German physiologist, C. G. Carus (1789–1869), and also Nietzsche. Freud (*Interpretation of Dreams*) is given due credit for emphasizing the relationship between dreams and the primitive mental apparatus, and likewise Jung (*Psychology of Dementia Praecox*) for showing the relationship between dream activities and schizophrenic thought as well as the many parallels between the phantasies of the later and archaic myths (*Psychology of the Unconscious*). Storch insists, however, that both Freud and Jung were too one-sided. Their analyses of archaic beliefs and fairy tales being undertaken and carried out exclusively from the viewpoint of certain psychoanalytic theories, they were led to questionable evolutional hypotheses. Other psychoanalysts he calls to account for a proclivity to rationalize too readily—*i.e.*, to deal with vague, obscure tendencies and feelings as if they were definitely circumscribed thoughts. The author admits that in describing these conditions a certain amount of rationalization is indispensable, but he proposes to avoid the errors of the above mentioned workers by "entering deeply and in an unbiased manner into the life of the schizophrenic, on the one hand, and into the ethnological material, on the other". Instead of focusing on the *content* in the archaic-primitive and the schizophrenic sphere, he has attempted to work out resemblances in their thought *processes* and *emotional attitudes*. He calls this the genetic approach, as opposed to the descriptive of Kraepelin and the dynamic of Freud and Jung.

The monograph is divided into three sections. Section One deals with the motor and thought tendencies in schizophrenic as compared with that in archaic man. The author cites from case histories some interesting praecox mannerisms and parallels them with observations made on dogs and chimpanzees who expressed their wishes by pantomime, and with certain magic performances of Australian, New Guinea, and other tribes. He brings numerous references from

anthropological literature to illustrate the view that primitive thinking employs "full concrete pictures" instead of abstract ideas, and uses practically the same images and symbols as are found in schizophrenic thinking.

Likewise anthropologic references are cited in juxtaposition to praecox delusions to show that in both the consciousness of self is a very hazy one and that there is a fusion of the ego with the objective world.

In Section Two the author brings a wealth of material from observations made on primitive races and compares them with those made daily in our mental hospitals. Both show a strikingly similar emotional attitude. Both are much concerned with such mental experiences as magic change of sex, mystic union with the parent or loved one, identification with the cosmos, and rebirth. Catatonic stupor is likened to Jhana, on the threshold of Nirvana, the mystic holding himself in "full motionlessness". The fetal attitude observed on our praecox wards is compared to the Rigveda, an attitude still preserved in the Yoga customs.

Section Three is devoted to the limitations of the point of view of genetic psychology. The author states that during the height of a praecox upset, the schizophrenic may be regarded as having sunk back entirely into a primitive world of feeling and thought, but that when the acute stage subsides, he lives in a twofold world—in the primitive world of percept images, magic relations, and so forth, and on the other hand, in the world of his earlier logical experiences. The concluding pages are devoted to a formulation of an etiological statement to explain the sinking back to primitive levels. This, in the reviewer's opinion, is the weakest part of the monograph. To be sure, the author himself states: "We will limit ourselves to a few indications which are not regarded as being a complete theory of schizophrenia . . ." But the reviewer feels that when the author asserts: "We assume that there has been a weakening of the rational superstructures caused by the schizophrenic pathological process . . . ", he is leaving the question of etiology just where it was left by Freud and Jung.

This monograph is not "light reading" and probably will not appeal to the average physician or to one who is only superficially interested in psychiatric problems. Nor is it a book for beginners in psychiatry. The author, however, has done a remarkable service to what might be termed the embryology of psychiatry by bringing together so much material from authentic original sources. He has opened wider the door pried open by Freud. The translator is to be thanked for making this work available in English. Physicians

and others who are really interested in the problems of dementia praecox will find a reading and even a rereading of this monograph well worth while. H. L. Levin.

Buffalo State Hospital.

Public Health in the United States; An Outline with Statistical Data. By Harry H. Moore. New York: Harper and Brothers, 1923. 557 p.

Haven Emerson's introduction describes Moore's volume of experience well as a "*vade mecum* for the lecturer, the school-teacher, the magazine writer, a philosophy of social action, a compendium of facts which reminds one in every chapter, to our humiliation, that we know infinitely more than we use". Dr. Thomas W. Salmon and other experts besides Dr. Emerson have rendered aid to Mr. Moore of the United States Public Health Service in the production of this outline of public health.

A short account is given of man's concern through the ages for his health, followed by a multitude of topics under the main headings: the human and economic costs of disease, the warfare against disease, the exploitation of ignorance regarding disease, the conquest of disease by health, and the expanding field of public health.

Mental defect, disease, and hygiene receive considerable notice in various parts of the book to which one is referred conveniently by the index. A chart on page 290 depicts the organization of mental-hygiene activities in a large city. Mr. Moore takes it for granted that the sanitarian will be actively concerned with the promotion of mental health.

A satisfactorily exhaustive treatment of the numerous public-health specialities is not, of course, to be expected under one cover. The bringing together of the many topics, however, facilitates reflection on the relationships of the various health activities.

The eighteen appendices comprise not the least valuable portion of the contribution. In six of the appendices mortality rates and miscellaneous health data are compared specifically by states.

A unique feature of the volume is the abundance of references throughout the text to the sources of the detailed information furnished. Readers who wish more complete information regarding the various topics will be pleased with the thirty-six pages of notes specifying sources.

Moore's compendium, like a dictionary, is difficult to read consecutively, but the book is a mine of compact, useful information concerning public health. Archibald S. Dean.

New York State Department of Health.

REFORMATORY REFORM. By Isaac G. Briggs. New York: Longmans, Green and Company, 1924. 227 p.

"The desire for sensationalism, so prevalent in this age, militates against quiet, rational investigation and suggestions, for a speech or book, if not startling, is considered of small value. The public palate has become so jaded with excitement that only a generously spiced dish will tickle it, and the temptation to season his dish with strong red pepper becomes almost irresistible to the earnest investigator who is convinced of the importance of his case, but can see no other way of rousing public interest."

So confesses the author of *Reformatory Reform* (page 194) in a volume partly autobiography, partly admonition, and partly a restatement of some of the principles of juvenile penal therapy, long considered elementary in this country.

The first few chapters represent the author's feeble and unsuccessful attempt to resist the temptation referred to above. They record his adventures in an English reform school, a semi-public training school for boys of from twelve to twenty-one years.

The "strong red pepper" is fairly well sprinkled. He relates how he had to wash in the usual "foul water"; his food was a "nauseating mess"; he and his fellows "seldom laughed"; and "Smith", his warden, delighted in calling him "you little swine". In conformity with his own formula, "the earnest investigator", fearful lest the "jaded" public should overlook the real merit of his book (and there is some), concludes his personal experiences as follows:

"For three years I lived—in general—on slugs and dough, never sat on a chair, never saw a carpet, a picture, or even a piece of oilcloth, never a cup and saucer . . . never wore a collar or tie . . . never saw a daily paper. . . ." (Page 149.)

On finishing the harrowing tale, one can but wonder how the author ever survived his two terms at the school in shape to become (as we understand he is) a self-made, successful business man and a thoughtful student (as the latter part of his book indicates) of juvenile penology.

The author was, on his own admission, a bad boy. On like authority the school was a bad school. But the ideas expressed in his book indicate that something, whether the school or not, has had the desired effect on him, for his book surely evidences the fact of one successful reformation.

Many other persons have spent a term in prison or reformatory, have profited by it, and have become successful citizens. Some of them have had the courage and intelligence to write about it, in the hope that they could thus improve the system of handling such

institutions. In America Frank Tannenbaum, Kate Richards O'Hare, Sophie Lyons, Roger Baldwin, Victor Eytinge, and others who have discreetly preserved their anonymity, and in England, John Howard (of blessed memory), Mary Gordon, Leonard T. Hobhouse, and Archibald F. Brockway, Jr., have alike succumbed to the irresistible temptation. Naturally the public accords a hearing to men and women who speak out of the bitterness of their own experience. It feels that their recommendations, being free from official bias, should be given weight. What a pity, then, that the injection of too much "red pepper" in these accounts is dulling the sensitiveness of the public palate to the real situation!

Most people, even the officials in charge, are inclined to believe in the soundness of the policy that substitutes constructive treatment for destructive punishment, at least with the young offender. Our ideals in America, at any rate, along these lines are clearly taking shape. The present difficulties consist in getting legislative support and financial backing and a personnel devoted and intelligent enough to carry out these ideals.

The second part of the book deals with some of the encouraging features of England's progress in dealing with the juvenile delinquent —the children's court, probation, reformatory and industrial schools, Borstal treatment, and after-care. Many, if not all, of the policies here approved have been in practice in many of our American states.

The third and really valuable part of the book is entitled *A Critical Consideration of the Problem as a Whole.* This is the meat of the volume. Whether it would be or will be consumed very generally without the "red pepper" is not quite certain. It is to be hoped, however, that the student of delinquency will not allow the sprinkling of so much condiment to obliterate the taste of the real viands.

Very little of the author's program is original. He approves the trial of trifling offenses out of court, truant schools under the educational department, preliminary examination of all more serious offenders, a children's division of the court, coöperation with parents, compulsory probation for first offenders, reparation to go with probation, the abolition of formal conviction until the age of prison commitment is reached, keeping reporters out of court, and the abolition of "birching". None of these recommendations have an air of novelty to the American penologist.

For those juveniles who have failed to respond to the above treatment, he proposes a definite commitment for at least three years in a school especially designed and constructed for the purpose. His arguments against the indeterminate (more properly called the indefinite) sentence, so generally favored in this country, are novel,

but unconvincing and contrary to the ideas of most writers and administrators to-day.

The author here makes a point many times overlooked by enthusiastic advocates of the indefinite sentence who use the analogy of a prisoner to a hospital patient to indicate the futility of fixed-term sentences. He calls attention to the fact that (1) the hospital patient wants to get well, and (2) the hospital doctor can demonstrate recovery by clinical tests before releasing his patients from the hospital; thus reminding us that, try as we will to treat our criminals scientifically, we have always to deal with that stubborn and recalcitrant factor, the prisoner's will.

The author stresses the need of a practical vocational education and deplores the time wasted in "education not bearing on the trade". (Page 215.) "Under this system history, 'gograffee', arabesque, drawing, tonic sol-fa singing, and the like would be ignored". How the author would have sympathized with the Tammany applicant for the position of mail carrier who quit the civil-service examination when asked how far it was to Alaska!

Religion alone is unavailing, says the author, to induce a boy to be satisfied with his "drab lot". He wants many of the pleasures of life, and it is the duty of the state not to attempt to reconcile him to foregoing these pleasures, but, through "practical" trade instruction, to make it possible for him to enjoy them.

The writer closes his book with a brief statement of what an institution for juvenile delinquents should be from a structural or physical standpoint. His specifications are good. Here, again, but few of them are original; most of them are elementary. A few of his recommendations are novel, at least to the reviewer—finger bowls and napkins to stimulate neatness, dancing with "outside partners", and "an ancestor's gallery of 'old boys' who have done well".

Students will find the last part of the book a helpful restatement of principles, and if the "slugs and dough" and the rest of the "red pepper" cause a few people to read it who otherwise wouldn't, the obvious exaggeration of conditions in one English training school may be overlooked.

SANFORD BATES.

Massachusetts Department of Correction.

MAN'S JUDGMENT OF DEATH. By Lewis E. Lawes. New York: G. P. Putnam's Sons, 1924. 146 p.

The content of this book is more explicitly indicated in the subtitle: *A Comprehensive Analysis of the Operation and Effect of Capital Punishment, Based on Facts, Not on Sentiment.* Warden

Lawes outlines briefly the history of capital punishment, and shows how in early England it did not serve to lessen crime. It is his opinion that the abolition of the death penalty will come to pass not alone from religious, moral, and ethical reasons, but because scientific research will reveal its uselessness. The weakness of the death penalty as a deterrent is discussed in an ingenious fashion and with a note of satire. The author's survey or investigation shows no uniform judicial statistics available for the country as a whole, regarding the number of homicides, indictments, judicial procedures, convictions, acquittals, and sentences. The statement is made that even records in state prisons on sentenced individuals are not all that could be desired. The need for a scientific survey of administrative agencies charged with law enforcement, detection of wrongdoers and their prosecution, and the results of the punishment inflicted, is stressed. Capital punishment as it exists to-day is delineated, and consideration is given to actual experience throughout the country with respect to the operation of the death penalty, as well as to life imprisonment. A comparison on a percentage basis of executions in relation to sentences is set down for representative states in this country. Tables are given which exhibit a possible relationship of sentences, executions, and homicide rates, including tables based on French, English, and Canadian statistics. A discussion of the effect of the death penalty upon lynching is presented. Foreign homicide statistics are also given, representing a considerable expenditure of time and effort on the part of Mr. Lawes in gathering and relating these data in an illuminating manner. The writer's personal opinion is set forth at several points in the study, and in justification of conclusions against capital punishment, he marshals a well-chosen batch of statistics and points out concisely the deductions that must be drawn from them.

The book includes a brief, but forceful foreword, Appendix A (51 pages of tables and charts, which have been analyzed in the preceding 80 pages of text), and Appendix B in which are set forth the written opinions on capital punishment of a number of penological experts. In gathering and correlating the indicated statistical information, Warden Lawes has rendered the intelligent public a distinct service.

Clinton P. McCord.
Board of Education, Albany, N. Y.

Immigration Problems. By Victor Safford. New York: Dodd, Mead, and Company, 1925.

This book is a discussion of "immigration problems" in only a very special sense; the "problems" are those encountered in enforcing the immigration law of the United States at the port of entry.

The writer of the book, a former officer in the medical branch of the immigration service, who took up his duties at the Port of New York in the nineties, draws upon a wealth of experience to show us the difference between theory and practice in the framing and administration of an immigration law.

He tells us story after story of the successful devices of immigrants and their friends to "beat the law", of the personal and political relations of officials that hinder its impartial and efficient operation. He assures us, however, that the immigrant inspection force is at least honest—that less grafting goes on than we might suppose.

He has little patience with social workers, "uplifters", philanthropists, and sentimentalists generally. He is not enthusiastic about some of the new methods of administration proposed. "Selection" of immigrants abroad, so desirable theoretically, he thinks will be difficult to carry out in practice. The rapid medical examination of former years, so severely criticized by most students of the immigration problem, he defends, on the ground that the experienced eye of the medical officer can catch indications of physical defect in the immigrants as they pass before him, from their movements and behavior, even better than from detailed medical examination of the immigrant at rest only, especially in certain types of disease. And the steerage immigrant, he says, is generally healthy, more so than the cabin passenger, so that a thorough examination in each case would be a waste of time and money.

Much plain foolishness, he says, has been exhibited on the part of advocates of intelligence tests, but progress has been made toward putting these on a reliable basis.

Dr. Safford's attitude toward the immigrant and immigration is, on the whole, unsympathetic. Although he admits the existence of a type of immigrant—self-reliant, able to care for himself, soon absorbed in the mass of the population—who possesses qualities commanding respect by all, the impressions and recollections that make up the greater part of the book are almost entirely of the unpleasant traits, the undesirable peculiarities of the newcomers.

His first impression of immigrants on his first visit to Ellis Island was that they carried hard and angular baggage which bumped into him. And this is, in sum, his impression of the immigration problem as a whole—an awkward, heavy, sharp-cornered bundle to be passed on from hand to hand and got rid of as firmly and as rapidly as possible, in so far as it has to be handled at all.

KATE HOLLADAY CLAGHORN.

New York School of Social Work.

MAN AND HIS AFFAIRS FROM THE ENGINEERING POINT OF VIEW. By Walter N. Polakov. Baltimore: Williams and Wilkins Company, 1925. 233 p.

Mr. Polakov's book will undoubtedly prove interesting to many a lay reader who would ordinarily shrink from any reference to mathematical philosophy. After reading a few chapters, one notes with surprise that the author's presentation of the subject is comprehensible and far from dull. However much one may disagree with his conclusions, one cannot fail to admit that he has succeeded in stimulating interest in a subject of which the average reader knows little. The chapter entitled *Relativism in Human Life* is an excellent introduction to the subject. More than one reader will turn from the perusal of *Man and His Affairs* to consult Keyser's *Mathematical Philosophy,* from which work Mr. Polakov quotes at length.

Mr. Polakov's book, however, will be of little value to the student of psychology. Although the author speaks of "the new postulates which square human conduct with human nature"—a phrase by no means antagonistic to the tenets of dynamic psychology—his exclusively mathematical perspective renders him incapable of comprehending human nature. His interpretations are purely intellectual, and he finds emotional phenomena unintelligible. He has a masterly way of exposing man's weaknesses (with which he has little sympathy), but he optimistically declares that all these manifestations of our haphazard existence may be transformed by scientific thinking. The reference to education is particularly interesting. Mr. Polakov delivers an excellent tirade against present educational systems, but his proposed reforms, which he considers inevitable, give one the impression of tending irrevocably toward that standardization which he deplores in the present system.

In summing up, one might say that the value of this book lies in whetting curiosity rather than in offering solutions for the problems of man. Nevertheless, it is the latter target that Mr. Polakov aims at—and, of course, misses. The admixture of what might almost be called propaganda is a distinct advantage throughout the book. There are passages that sound as if Mr. Polakov were conducting a revival, and to many of us the prospect of a mathematical Utopia is no less appalling than that of the reformer's heaven.

RUTH LIEBMAN.

New York City.

NOTES AND COMMENTS

District of Columbia

A bill to establish, in the Bureau of Education, a division for the study of the mental and educational needs of backward, mentally deficient, and otherwise mentally handicapped school children, is before Congress.

This bill has the same provisions as one that failed of enactment in the last session of Congress. It was summarized in the April, 1925, issue of MENTAL HYGIENE.

A bill before Congress would grant free hospital treatment to postal employees suffering from tuberculosis, nervous diseases, or kindred occupational ailments in hospitals of the United States Public Health Service or the United States Veterans' Bureau.

A bill to establish a laboratory for the study of the abnormal classes is before Congress. It would be in charge of a director, appointed by the President, with the advice and consent of the Senate, whose salary would be $7,500 per year. His assistants would include an anthropologist, a criminologist, a psychologist, an alienist, a neurologist, and a statistician, each at a salary of $5,000. Other personnel would be a translator, six stenographers, three clerks, and three messengers. This laboratory would be established in the United States Public Health Service, and its work would include both laboratory investigations and the collection of sociological and pathological data, especially such as may be found in the institutions for the insane, dependent, defective, and delinquent classes. The purpose of its investigations are stated to be "the prevention and lessening of social evils through knowledge and the education of the public in these subjects gained by the scientific study of their causes".

Legislation to establish a board of public welfare for the District of Columbia has been introduced in Congress. These bills are very similar to those presented in former sessions, one of which was summarized in the April, 1924, issue of MENTAL HYGIENE.

Massachusetts

A bill before the 1926 legislature would authorize the construction of a new state hospital for mental diseases in Waltham.

New Jersey

A sterilization bill is before the 1926 legislature. This bill is identical with one introduced last year, which passed in the senate, but failed in the assembly.

New York

A bill is before the 1926 legislature carrying an appropriation of $50,000 for the furnishing and setting into operation of the reception clinic at Sing Sing Prison. This state has been committed to such a clinic since 1916, and the building for it has been ready for use nearly three years. The bill provides the sum of $25,000 for a psychiatrist, to be in charge of the clinic, and such assistants as may be necessary. The remaining $25,000 is to be devoted to equipment and furnishings. The psychiatrist is to be appointed by the state superintendent of prisons.

Another bill, amending the prison law in relation to the duties of physicians in county jails, contains the following new provision:

"It shall be the duty of such physician to examine each person committed to the jail and to ascertain if such person is suffering from or afflicted with any contagious, infectious, or communicable disease, and in the case of all persons charged with a criminal offense, to ascertain if such person is a mental defective or insane; and report to the sheriff, in writing, the result of such examination."

Another bill would appropriate one million dollars for fire prevention and safety measures at such state hospitals and charitable institutions as may be designated by the governor, the chairman of the senate finance committee, and the chairman of the assembly ways and means committee.

A state psychiatric hospital at Syracuse University is provided for by a bill now before the 1926 legislature.

According to the terms of another bill before the 1926 legislature, private institutions for the treatment of narcotic drug addiction must be licensed by the state hospital commission. If enacted, this law will go into effect January 1, 1927, except that applications for licenses may be made to the commission and the commission may make all necessary examinations and grant such licenses from the date on which it becomes a law.

A 1926 bill, amending the penal law, allows the jury to find a verdict of "guilty, but insane", in the case of mentally incompetent persons. When this verdict is rendered, the following procedure is authorized:

"(1) A person, who is found guilty, but insane, in a case where the crime charged is or may be punishable by death or by imprisonment for life in a state prison, if he were not incompetent, shall be sentenced to confinement for life in a state hospital for the criminal insane, with the proviso that in case he becomes competent, he may apply to the governor to be thereafter confined in a state prison.

"(2) A person, who is found guilty, but insane, in a case where the crime charged is or may be punishable for a term of years, shall be sentenced to confinement in a state hospital for the criminal insane, for such term as the court would sentence him if he were not incompetent, with the proviso that in case he becomes competent prior to the expiration of such term he may apply to the governor to be thereafter confined in a state prison. When the term for which such person was sentenced expires and such incompetency continues, the provisions of sections one hundred and fifty-nine and one hundred and sixty of the insanity law[1] shall apply in whatever state hospital for the criminal insane such person shall then be confined."

Another bill before the 1926 legislature, amending the education law in relation to the supervision of children with retarded mental development, contains the following new provision:

"In every county of the state there may be a county supervisor to supervise the education of children with retarded mental development as defined by this article. In counties within the city of New York there may be such additional supervisors as may be necessary and shall be determined by the board of estimate and apportionment. The salaries of such supervisors shall be a joint charge against the cities, union free school districts, and school districts within the county, but the state shall apportion to such city or district, in the same manner as teachers' quotas are apportioned thereto, an amount equal to one-half of the salary paid to each such supervisor and charged against such city or district. The amount of the salary to be paid to supervisors shall be determined by the legislative authority of the county. No person shall be a supervisor unless he be a duly licensed physician with at least five years' experience in the treatment of mental disorders and diseases. The children mentioned in this article shall be given special courses of mental training under the general direction and supervision of the supervisor. Such children shall be required to attend such special courses until they are eighteen years of age."

A bill to authorize the transfer to the state of the land in New York City on which the State Psychiatric Institute and Hospital is

[1] These sections relate to the retention of insane convicts after the expiration of their terms and the discharge of such convicts, respectively.

being constructed is before the legislature. This state institution is being erected in connection with the new medical center that is being developed jointly by Columbia University and the Presbyterian Hospital.

Porto Rico

The Porto Rican Child Welfare Board was created by an act of the 1925 legislature. This board is to have charge of the study of all problems affecting childhood, to revise present legislation on the subject, and to inspect all institutions for children. It is to report to the legislature each session concerning the operation of such institutions and recommend such measures as it deems necessary for the benefit of childhood. The members are appointed by the governor, with the advice and consent of the senate, for a term of two years. The board consists of five members, two of whom must be mothers. The commissioners of health and education are *ex officio* members. The secretary, appointed by the commissioner of health on recommendation of the board, must be a person of recognized ability in social study and work, especially in regard to infancy. The office of the board is located in the department of health.

Rhode Island

The Rhode Island Children's Laws Commission, appointed by the governor in April, 1925, in accordance with an act of the legislature of that year, has submitted its report to the governor and the 1926 legislature. It recommends the enactment of twenty-seven bills, among which is one to create a children's bureau in the state public welfare commission, for the protection of defective, dependent, delinquent, and other children. Another bill would provide for examinations to discover children three years or more mentally retarded, for establishing special classes in the schools for their instruction, and for prohibiting such children from obtaining work certificates at the age of fifteen years. The report recommends a state program for the mentally defective, and that the state establish a psychopathic ward or hospital to be used by the juvenile courts as a place to detain temporarily children in need of special study.

West Virginia

The State Hospital for Colored Insane, established by an act of the 1919 legislature, was opened February 1. This institution, which is West Virginia's fourth state hospital, is located at Lakin in Mason County. It will receive colored persons with mental disease, and also colored epileptic and feebleminded persons.

More—and Better Religion

Editorial, *The New Republic*

"I have tried to indicate what I think the country needs in the way of help under present conditions. It needs more religion. If there are any general failures in the enforcement of the law, it is because there have first been general failures in the disposition to observe the law. I can conceive of no adequate remedy for the evils which beset society except through the influence of religion."—*Extract from a recent address by President Coolidge on the increase of crime, delivered to the National Council of the Congregational Churches of America.*

There is a mixture of understanding and misunderstanding about Mr. Coolidge's advice to his fellow-countrymen on this as on other occasions which challenges analysis. His general thesis is that the social problem created by the increase or even the existence of crime cannot be dealt with adequately either by government or secular education. Only the Christian churches, acting as the spokesmen of religious authority, are capable of infusing into erring men and women the needed disposition to lead a good life. There is something to be said for this contention which we shall say presently. But as the President has stated it, it will not do. He would convert religion chiefly into the handmaid of government. He conceives the church as the trustee of a conventional legal and moral code. Finally he is in effect asking the clergy, who are at present wholly impotent to deal remedially with crime, to share with political officials a responsibility which belongs primarily to the latter and which they are now bungling and shirking to a wholly unnecessary extent.

The truth about crime which Americans most need to realize at present does not concern the ultimate inability of the state to remedy the whole evil. It concerns the failure of the state to do as much as it can to moderate the existing volume of crime. Other governments and the American government at other times have shown much more efficiency in this respect than the several American governments now show. The public officials who are engaged in detecting, prosecuting, and judging criminal acts are not as capable and conscientious as they should and can be. They are not themselves sufficiently conscious of the causes, the extent, the consequences, or the remedies of their own failure. They have reason to conceal the truth from themselves. They obtain their power as the result of a partisan distribution of political offices and a partisan control of electoral machinery which it is important from their point of view not to disturb. They are not appointed, dismissed, or appraised with much reference to their zeal or efficiency. It is almost impossible accurately to estimate the value

of their services to the community. They have never established or permitted to be established any agency which accurately records their official behavior and tests their official capability. At the very moment when every citizen of New York, for instance, knows that life and property are shamefully insecure, the police department gives out statistics to prove that crimes of violence are substantially falling off.

In this and in many other ways the government obviously can do very much more to detect, to punish, and to prevent crime than it actually does. In dealing with the problem it will need assistance from non-political agencies, but manifestly there is one group of people, not politicians, who are much better educated to furnish this assistance than are the clergymen. We refer, of course, to some of the anthropologists. There is an increasing body of scientific knowledge which throws light on human pathology and which, if the law and professional prejudice allowed, might render help to police departments, prosecuting attorneys, and judges much more than it now does to diminish crime. In fact it would superficially be much truer to say that what America needs as an adequate remedy for the evils which beset society is more knowledge of human behavior rather than more religion. Christian religious authority has exerted at one time a more effective influence on practical conduct than it does to-day, but in those days of comparative clerical prestige society suffered more than it does now from the menace of crime and from impotence to deal remedially with it. The Christian Church has not at any time in its history displayed much ability or much desire to diminish crime. In fact, the clergy have often been as complacent about its existence as the police are to-day. Organized Christianity has from the days of its recognition by the state sought rather to console and spiritually compensate society for the existence of crime than to find a remedy for it. Often the clergy have conceived it to be the inevitable consequence of human depravity. Students of society are, consequently, counting less on official Christianity to remedy social evils than on science. Religion without science has been tried. Science with or without religion has not. The best chance at present of supplementing the necessary deficiencies of government in dealing with crime is to apply to it the spirit of patient investigation and the method of watchful experimentation which has accomplished so much in other regions of human experience.

It is important, consequently, to begin by recognizing that social problems such as crime cannot be dealt with adequately unless government seeks the assistance of scientific method as applied to human behavior. The failure to recognize this truth was unenlightened on Mr. Coolidge's part. Yet even if he had recognized it, he might still

with reason have insisted that the problem of crime, as one aspect of the much larger problem of "good" human behavior, was necessarily entangled with the amount and kind of authority which religious motives exercised over the lives of the ordinary American. Whether or not and how far crime exists in any community will always depend in part on its government, its social institutions, and its humane knowledge, but crime, wherever it exists, is ultimately a matter of particular choices by individuals, and the religion of any community is its organized conscious attempt to induce individuals to choose well. No matter how much Christianity may in the past have failed to assist government in dealing remedially with crime, it will in the future have to assume a larger share of the social responsibility for the existence of crime. It will, that is, if it is to continue to play the part of the official religion of an enlightened modern community.

When President Coolidge pleaded in his address to the Congregational ministers for more religion, he would have done well to put in a plea also for a religion somewhat different in quality. The kind of Christianity which is now preached from the great majority of American pulpits is no doubt a spiritual comfort to millions of people and a capacious reservoir of social standards; but it has never exercised as profound an influence as it needed to exercise on individual conduct, and moreover it has of late years been losing at least part of its former authority. Protestant Christianity in America no longer acts as if it possessed any faith in its ability to control individual behavior. Two generations ago when the churches sought to combat the evils of intemperance, they organized revival meetings and exacted individual pledges of total abstinence. To-day they accomplish the same purpose by demanding prohibition. The great majority of them appraise the 18th Amendment and the Volstead Act as a satisfactory example of practical Christianity. The churches summon the state to abate by force an evil which they cannot abate by religious authority: viz., the propensity of supposed Christians to become liquor addicts. Nevertheless crime increases and so does the disrespect for law. Then the state in the person of President Coolidge summons the clergymen to assist in obtaining obedience to laws which had to be passed because laymen persisted in ignoring the admonitions of these spiritual censors. The guardians of society seem at times to get their signals mixed.

In the past the clergy have depended for their influence on popular conduct too much on moral coercion. For many centuries they were licensed to threaten the sinner with everlasting suffering in hell and to promise to the faithful everlasting beatitude in heaven, and during this period of moral terrorism they themselves were chiefly spiritual policemen who were armed to prevent laymen from

going wrong. In their attempts to control individual conduct, they still invoke the authority which they derive from popular belief in their peculiar access to the sources of righteousness and truth. But this authority is being seriously undermined. The layman is increasingly sceptical of the dogmas which vindicate clerical authority, and this scepticism is merely a deserved and appropriate penalty of the notorious disputes which rage among the official spokesmen of Christianity about its essential meaning. They are losing the prestige which formerly enabled them to obtain some response from laymen to their moral admonitions. At the very time when President Coolidge is calling upon the clergy to bring religion to the assistance of the state, the fundamentalists are proposing to employ the state schools for the purpose of restoring the waning authority of official Christianity. It will be wiser for the representatives of both state and church to consider why they perform their own proper functions so badly rather than to try to escape the consequences of their own failure by calling a no less wobbly partner to their assistance.

Official Christianity is powerless for one obvious reason to answer President Coolidge's call for help. It has never negotiated a satisfactory agreement with the spirit and method of natural science. Of late years an increasing disposition has existed among some men who call themselves scientists to dispute with the clergy the monopoly which the latter have traditionally enjoyed as the custodians of the truth which makes for human liberation. While individual and social psychologists are still far from justified in claiming a knowledge of human nature so trustworthy that from it they can give instruction in the art of living, they are nevertheless steadily improving their methods of investigation and the value of their results. On the other hand the clergy are standing still or falling behind. There is no doubt a small minority of liberal Christians who are doing what they can to associate Christian promise of redemption with a methodical inquiry into the processes of human behavior, and who expect by this means to emancipate official Christianity from its bondage to traditional rules and principles, but they have made little impression on the mass of the clergy. The great majority of ministers still assume that they know all they need to know in order to do their work. As they see it, their all-important task remains that of exhorting their flocks into accepting their belief as to truths and in following their advice as to conduct. This assumption is undermining the authority of the churches. It is preventing Christianity from exerting the influence which it ought and needs to exert on the way nominal Christians live. For Christianity cannot become, as its Founder proposed, essentially a way of life unless its ministers fully realize the impossibility of redeeming human lives by obeying rules

or repeating dogmas. They must lead their flocks to consult life itself in its aspect of conscious methodical experience for the light which they need to carry on the task of human regeneration.

Spiritual Healing: An Ecclesiastical View

The following account of a churchman's views on spiritual healing appeared in a recent number of the *British Medical Journal:*

"The Bishop of Durham, Dr. Hensley Henson, in his address to the Durham Diocesan Conference on Saturday, March 14th, spoke at some length about spiritual healing. He asserted that spiritual healing meant no more and no less than mental healing, that the faith which effected the marvelous healings of ecclesiastical record and created a number of miracles about saints and shrines, need not be distinguished from suggestibility. Faith healing was common to all religions, and there was nothing distinctively Christian about the 'Christian healing' described by Mr. J. M. Hickson. In the bishop's opinion, Mr. Hickson's conception of faith hardly rose to the Christian level; his notion of prayer seemed frankly pagan, and his reading of Christian history quite mistaken. On Mr. Hickson's view it would appear, said the bishop, that his healing power was co-extensive with that of Jesus as described by the evangelists; but it did not appear that Mr. Hickson had claimed to have actually raised the dead, although his ability to do so was clearly implicit in his general position. Dr. Hensley Henson observed that the science of psychology was throwing a flood of light on that obscure region in which the psychical operated upon the physical. The healing of disease was the incommunicable task of the physician; and the Christian ministry was not charged, and could not seriously concern itself, with this healing. When Mr. Hickson called upon the Church to revive this part of her ministry—physical healing—which he alleged had been lying in abeyance so long, the bishops owed it to the Church to declare their deliberate judgment. Mr. Hickson, in his enthusiasm for 'spiritual healing', was led to use language which implied that the cessation of a healing ministry in the Church had been calamitous to mankind. When miracles of healing were most numerous, the bishop observed, public health was least satisfactory. The wonderful advance in medical science had been conditioned throughout by its hard-won independence of theological presuppositions and ecclesiastical control. 'It cannot be the duty of the Church', concluded the bishop, 'deliberately to return to the beliefs and methods of a primitive and superstitious past.' Bishop Hensley Henson, when Dean of Durham, sat on the committee on spiritual healing which met at Westminster under the chairmanship of Bishop Ryle, Dean of Westminster, and presented

a unanimous report to the Archbishop of Canterbury in 1914. He had the opportunity, therefore, of hearing and examining the witnesses who gave evidence before that committee. Mr. Hickson was unable to appear before the committee; in fact, it does not appear that any official investigation of Mr. Hickson's cases has taken place since the British Medical Association appointed a committee to investigate in 1909. . . . According to the Bishop of Durham, Mr. Hickson admits that the testimonies to his cures fall short of what might fairly be required, so that in the absence of scientific diagnosis before the Bradford mission and examination afterwards they could not be decisive. But Dr. Hensley Henson's opportunities for hearing the claims of healers and for judging the standard of validity in evidence required by medical men have been larger than those of many of his fellow bishops. As a result of these opportunities, the bishop, while professing no concern with the faith healer's gift, which, he says, Mr. Hickson appears to possess, expresses the view that Mr. Hickson would be wise to exercise the gift with caution lest he should do irreparable injury to those who sought his aid. In the bishop's opinion the sphere of conscience is preëminently the sphere within which the clergyman's duty is unquestionable. The modern physician can discern the nature of the psychic trouble which arrests and defeats physical treatment, and his knowledge might lead him to desire the clergyman's distinctive service. The bishop's remarks strike us as sound sense, and (if we may venture to say so) as sound doctrine, too."

Social Work and Psychiatry

Editorial, *The Journal of Neurology and Psychopathology*

Our whole psychiatric outlook will naturally be molded according to our conception of the basic factors of mental disorder. Roughly speaking, we have three schools of thought in mental medicine. There are those who hold a strictly materialistic view and who found the symptoms upon morbid changes in nervous structure which supposedly result from infective agents, blood disorder, endocrine imbalance, etc. Another sect adopts a purely psychogenic aspect, and bases mental pathology upon mental conflict and warfare between instinctive desires and personality. Others take a wider viewpoint and see in the neuroses and psychoses a biological maladaptation to environment. According to the stress we lay upon these basic conceptions, so will our ideas of the importance of different prophylactic and remedial measures vary. The materialistic school will tend to correlate mental hygiene with general measures conducive to physical fitness; we still hear the fallacious shibboleth that if only the evils of

alcohol and syphilis were removed, mental disorder would be half eliminated. Since we must look upon the organism and its reactions as an integrated whole, physical hygiene must not be lost sight of, but as the one and only aim in view such a stressing must be deprecated. The psychogenic school has undoubtedly thrown a flood of light upon regions of mental aberration which were previously obscure, but again we cannot but think that their theories are often apt to be so ultra-scientific that failure from the pragmatic point of view constantly accrues.

If we adopt a wider psychobiological conception of mental disorder and strain our energies on such lines, the results to the community may be more far-reaching. A psychotherapist cannot be manufactured by mere psychological and neurological training. There must be "*au fond*" in him mental characteristics, a personality, which will enable him to sum up an individual, recognize his type, empathize his feelings, and almost intuitively grasp the exigencies of the case. Even such an ideal psychiatrist as we picture is handicapped in that he has usually only the opportunity of seeing the individual, when, from the point of view we inculcate, it is the individual in conflict with his environment that is so largely responsible for the mental breakdown. Without a knowledge of that environment the psychiatrist may be helpless, and what he gleans from the patient himself may naturally be almost worthless since the neurotic and psychotic have distorted mental views. If, then, we would attack psychiatric problems from the wide point of view of the community as a whole and see herein the vast question of interplay between individual and environment, the knowledge of the latter may be as important as, or even more than, the former. If environment cannot be modified, then the individual must alter his adaptation or the neurosis must continue. We wish to stress the point that a so-called mental breakdown may be, and often is, more an economic, domestic, or social problem than a medical one. It is this fact which is so often lost sight of by the neopsychiatrist, who tends to wrestle with infantile complexes at the expense of dealing with environmental conflicts. Following Herbert Spencer's *dictum* that life is a continuous adjustment of inner to outer relations, we must not, as we are apt to, leave these latter out of our study. As Southard pointed out, it is important that the mental sciences should study not merely life's inner relations *as such* and life's outer relations *as such,* but also the adjustments of interrelations of the two.

All this leads up to the theme that social work is a necessity as an adjunct to psychiatry. Beneath the individual problem which the patient brings there is an added underlying social problem, of which the psychiatrist knows nothing, and this is the reason, in all prob-

ability, that he so often fails to effect a cure, notwithstanding that he has carried out a very perfect therapeutic method. The main mass of mental material will always be treated at out-patient hospital departments or clinics, where even if the physician knows of the social problems to some extent, he cannot adequately evaluate them, cannot devote much time to their discussion, and is impotent to deal with much that they involve. It is tragic to reflect that such out-patients continue year after year to visit such institutions, only to receive a few banal words of advice and a repeat mixture, when the real sources of the neurosis have never been traced. In the vast majority of instances our armchair methods of psychotherapy fail. The valuable time taken up in obtaining the necessary personal histories of these patients could be devoted to the really important medical factors if a social worker had previously provided all such details. We should find, too, that with the provision of this information at the outset, our diagnosis and treatment would be greatly modified. It is by no means uncommon to find that, with added knowledge of a "longitudinal section" of a case history, what was regarded as anxiety hysteria has really been a mild dementia praecox. In mental work cross-section surveys of a patient's history are almost useless.

When we speak of psychiatric social work, we refer to the evolution of a definite profession such as has been in evidence in America for some years. The untrained social worker is of little value. The worker trained in the various wide factors concerned in social adjustment will be in a position to collect all available information which in the hands of the psychiatrist will permit of rational diagnosis and treatment; to apply to the social environment measures calculated to relieve the mental stress which was provocative of the breakdown; to supervise the rehabilitation of the patient in his relation to society; to act as an intermediary between physician and patient, and carry out instructions prescribed by the former. We hear much nowadays about reform in the applications of mental medicine, and the necessity for early treatment, but much of this reconstructive energy might be directed on better lines. Early treatment, as we have tried to show, will be largely sterile unless outer social relations are duly taken into account, and this can adequately be done only through social service. The question of certification or non-certification in mental disorder does not lead us far. It is only a device for the dodging of the stigma attached, which will only be lessened by education and a closer touch between society and patient. Every society will have the mental sufferer it deserves. As society recognizes its responsibilities and as each patient is treated as an individual unit, progress may come about. It must

not be forgotten, too, that to a well-trained psychiatric social worker a vast field is opened up for valuable medico-social research. We have now in England our National Committee of Mental Hygiene. It might well commence its campaign by insuring that psychiatric social work shall go hand in hand with other progressive measures.

Heredity in Mental and Nervous Diseases

Editorial, *The Lancet*

The transmission from parent to offspring of mental and physical characteristics has been accepted as a fact from the beginning of time, but this principle cannot be applied to disease processes quite so simply. The complex living organism is made up of a number of individual entities together composing the whole, and in the consideration of the transmission of qualities the questions at once arise: Does the innate characteristic of the individual persist unchanged and is it transmitted in its unchanged form, or can the characteristic be modified during the life of the individual, and can this modified characteristic be transmitted? The Mendelian laws showed that in comparatively simple organisms, with clearly recognizable traits, the innate characteristic persisted and that the manner of its appearance in the progeny could be mathematically computed. The advent of Darwinism and the theory of sporadic variation further deflected attention from the second possibility, but opinion now shows a trend towards the neo-Lamarckian attitude which affirms that the acquired modification may, under suitable circumstances, be passed on. The Mendelian law is very hard to apply in the complex organism and more particularly in the field of disease. It is difficult, in the first place, to pick out the definite fundamental trait, the unit characteristic; what appears unitary may, in fact, prove to be highly complex. Apart from a very limited group of abnormalities, such as hæmophilia, albinism, and certain familial myopathies, very little in this line has actually been accomplished beyond the establishment of a certain persistence of characteristic in a family tree.

In medicine it has been the custom to introduce the heredity as an etiological factor in disease, especially in cases where no other definite causative factor is known. The history of pathological research, however, offers many instances where the hereditary influence was once supposed to be the all-important agent, when further advances in knowledge have shown the disease to be one acquired in the lifetime of the individual. In such cases, even where the disorder has been definitely proved to be due to an environmental cause, such as the invasion of micro-organisms, the exponents of the

hereditary theory merely change their ground and speak of a "diathesis" or a "constitutional tendency". Professor Abraham Myerson, in a work reviewed in our columns this week, emphasizes this point in relation to tuberculosis. He says:

"Up till Trudeau's time, in fact right up to the discovery of the tubercle bacillus by Koch, the main factor in the causation of the disease was held to be heredity. There were plenty of families found in which tuberculosis occurred 'generation after generation', plenty of families found in which all or many of the brothers and sisters had the disease, the same kind of evidence we have to-day for the 'inheritance of insanity'. . . . With the discovery of the infecting organism as a cause of tuberculosis heredity received a knock-out punch; in fact, every one now loudly proclaims that there is no heredity in tuberculosis, but instead the metaphysical 'predisposition' is acclaimed, and still lingers to obfuscate intelligent thinking."

The real obstacle, as it appears to us, in the way of any advance in our knowledge of the hereditary transmission of disease lies, firstly, in the difficulty of finding a "unit character". There are few diseases which can be so regarded: the majority are symptomatic groupings. Particularly does this apply to mental and nervous disorder, of whose ultimate nature we have at present little accurate knowledge and concerning which it is probable that future research will radically alter our conceptions. Secondly, we do not know how far a certain grouping of symptoms may constitute a biological reaction to certain specific environmental circumstances. Because a certain symptom-complex appears in a national or family grouping, it does not necessarily follow that the cause lies within. There is a strong measure of probability in the alternative explanation—viz., that the mechanism of biological adaptation to the environment is producing a similar series of reactions in a number of individuals exposed to the same conditions. Thirdly, we are remarkably ignorant of the laws governing degeneracy, atavism, or simple failure of development. It is a matter of consideration whether a number of the disease entities now recognized are not phenomena of this order rather than disease processes proper.

The progress of *homo sapiens* has been not biological, but sociological; it has depended upon his control of and ability to grow at the expense of his environment. The development of man is not reckoned in terms of biology, but in terms of his capacity for using materials—the Stone Age, the Bronze Age, the Age of Steam. There has been steady progress in the manipulation of the environmental factor, and it may be that the hope of medical science lies in a further extension of this principle. It is a comforting reflection that the

history of medicine shows a steady tendency to eliminate the hereditary in favor of the environmental cause as the knowledge of morbid processes has become more explicit. For it is still a question whether the advance of the human race depends upon the adaptability of man to his environment or upon his capacity for adapting the environment to himself.

Child Study Program of the Canadian National Committee for Mental Hygiene

The Canadian National Committee for Mental Hygiene has entered upon an extensive research program, to be conducted in coöperation with various Canadian universities. Arrangements have been made with the University of Toronto for a five-year study of mental and nervous conditions among school children, with the object of evolving a technique of prevention that can be applied to the entire school population of the Dominion. The study is in charge of Dr. A. E. Bott, Dr. J. G. Fitzgerald, Dr. W. E. Blatz, Professor E. MacPhee, and a group of assistants.

In Montreal, the assistance of McGill University has been enlisted in a five-year investigation of behavior problems among children, directed toward the discovery of methods of preventing future delinquency, illegitimacy, prostitution, and dependency. Professor J. W. Bridges and Dr. W. T. B. Mitchell are conducting the work.

Arrangements are also being made for a five-year study of children of pre-school age, to determine what factors are necessary for healthy mental and physical growth and to serve as the basis of a program of parent training in child development.

In connection with this research program, the Canadian National Committee, with the aid of the Rockefeller Foundation and the Laura Spelman Rockefeller Memorial, is granting seven traveling fellowships in mental hygiene. The research work will be financed by the Lady Byng of Vimy Fund for Mental Hygiene and the Rockefeller Foundation.

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MENTAL HYGIENE

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MENTAL HYGIENE: WISE AND UNWISE INVESTMENTS

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THE mental-hygiene movement has, during its brief span of eighteen years, proven interesting to the public. This is very gratifying, but it is also dangerous; for enthusiastic approval, unless well directed, is likely to encourage an investment of interest in certain ill-advised issues. Those of us in the professional ranks of a health movement have a double duty: to arouse in the minds of the laity an intense interest in the possibilities of the wise application of recently discovered truths, but also to warn them against blue-sky securities in this field of investment. The public's imagination, much aided by the press, loves to speculate on the possibilities of each scientific advance. We protest, but their reply is, "It's possible, isn't it?" "Why not?" But those actually in the work are in a better position to see just how impossible some possibilities are. The truth is that we all are by nature speculators: we love to take a long chance. The farmer, earning by hard, monotonous grind a fair living, is tempted to run at the first news of a new gold mine, and to spend his hard-earned savings for stock the description of which reads alluringly, and whose certificates are engraved in purple and gold. If he loses all, he regrets his rashness, but often he remembers with pleasure the thrill of the speculation. Persuade a person, however, to invest his emotions in a new social movement which later goes wrong, and he feels betrayed, personally injured; he doesn't like to have his affections carelessly played with. This gambling instinct of man, this desire of his to take a chance, is by no means as reprehensible as many

* Read before the American Health Congress, Atlantic City, May 20, 1926.

would consider it. It is one evidence of the force of creative evolution which has made it possible for us to climb to the heights we now have reached; it is the force within us which makes it possible for us to hope to reach better things. Those not willing to take a chance, to speculate with their interests and their efforts, soon become the crustaceans of society and marked for degradation. We should, however, not exploit this instinct of our creative nature; and while by meetings like this we advertise the possibilities of certain movements, we must ever have in mind the fact that few in our audience have the same experience as we, and that the others will later resent a bad investment of their personal interest.

We may illustrate by a recently published statement, from the field of physical hygiene, that some day man may live to be one hundred and fifty years old. "Why not?" they say. "The life of the majority of individuals is limited by the degenerative diseases and these same degenerative diseases are theoretically preventable." Now no one desires more than I do to live to an age of one hundred and fifty years, provided this increased lease of life is to be for a period of good physical and mental health. But here, too, medical problems are badly confused. It is true that theoretically controllable diseases prevent the great majority of individuals from reaching their threescore years and ten, or perchance fourscore years, and it is true also that those same diseases lessen for each of us the value of life during our latter years. But we have as yet no reason to believe that could we eliminate all of these same diseases, we would by so doing lengthen life beyond the fourscore limit. There are other mechanisms which determine that limit. Preventive medicine has helped and is helping a greater and greater percentage of babies to come nearer and nearer to that limit and will help still more; nevertheless every element of improvement of our much vaunted present-day civilization, with all its many aids and comforts, tends definitely to shorten life at its latter end—has already shortened it some say, although some explain this away. Nevertheless, it certainly has not been lengthened, nor can we as physicians see evidence of anything that tends to lengthen it beyond threescore years and ten, or perchance fourscore.

Mental hygiene promises to make this physical life more worth while, for who wishes to live on insane or demented? Can we make good our promises? Of course, if parents always set their children a good example and always taught them while young to be good; if the churches continuously used a reasonable amount of energy toward directing our minds to higher things; if the schools were conducted, not by mechanical routinists, but by people reasonably able to teach mental self-control and to help the children to think, then there would be no need for mental hygiene, but neither would there be any need for courts and jails. The truth of the matter is that most men must carry on until they drop; they cannot always follow our advice—not if it entails much reorganization of their lives—and like some lawyers who are said to spend their time not in teaching men to obey the law, but in showing clients how to evade the law and yet escape punishment, so we must show our patients how they may carry on and not break. Those who might obey too often will not. Life offers so many enticing speculations that they wish to take a flier, provided there is any reasonable chance of success.

The question, therefore, is one of reasonable speculation—not plunging, not gambling. We must mount upwards. Can we do so without increasing this enormous load which modern society carries, of insanity, of feeblemindedness, of social maladjustment, all of which is merely the wreckage of the unwise speculations of preceding generations?

At this point may we remind you that mental hygiene, a new subject, is not new because man has suddenly decided to interest himself in it, but it is rather the "next" subject in a logical sequence of an evolution of medicine which produced at first a medicine based on accurate pathology, then a psychiatry based on an accurate internal medicine, and now a mental hygiene based on psychiatry. Mental hygiene bears the same relation to psychiatry that physical hygiene does to internal medicine. Both are proving their right to our consideration; both now are in that period of development when our function is not to advertise new vistas, not to suggest new possibilities—these already are too numerous and too alluring—but rather to protect the public from an enthusiastic invest-

ment of its hopes in possibilities which, so far as we know now, may not be justified.

The first subject we now discuss is that of mental defectiveness, a problem that seems, like a black cloud, to hang over the minds of many interested in social welfare. It is indeed a problem, but not nearly so difficult a one as the amateur seems to believe. Unfortunately, eugenics now has reached popular literature, and books have been published, written in convincing style, by those who have only an academic knowledge of biology and no accurate first-hand acquaintance with chromosomes, genes, sweet peas, black- and red-eyed banana flies, and long-haired guinea pigs. Studies of families have been made by those who trust the family traditions of ignorant grandchildren and the gossip of neighbors, but who could not tell a moron or a child with dementia precox from one with adenoids. Papers have been written in which it is assumed that Mendel's law applies as well to complex mental processes as to the color of the eyes of a banana fly, and others which illustrate the moral obliquities of an unfortunate family by pictures of the chromosomes of, perhaps, a star fish. Books are widely read in which the author assumes as proven for man the laws of biology as yet doubtful for guinea pigs, and in which it is assumed that the inheritance of mental traits follows the same general plan as the inheritance of brown eyes and red hair. But fair play prompts me to criticize also those who read these books. It is a sad fact that the religion of Jesus Christ has as yet neither bred out nor driven out a certain cruelty and selfishness of natural man, no, nor of woman either. At a recent meeting of a women's club, the membership of which included the best and the best educated of women, when social betterment was under discussion, they cried out saying, "Sterilize them! Sterilize them!" Now we would urge that while we may know something, but little enough, of the laws of inheritance of unit atomical characteristics, we know much less of the inheritance of mental characteristics and absolutely nothing at all of the laws which determine how much of a mental characteristic or ability is transmitted, even granting that these are inherited. Second, we overlook too much the potent influence of environment, we underestimate the effect and influence of the exam-

ple of parents and other children, and we forget the influence of actual instruction, all of which influences are potent before four years of age. And, third, we use the term "inherited" in two different senses, including all the results of pathological and nutritional disturbances. The same disease may run in four or more generations of the same family and yet not be inherited. One forgets that the child has nine months before he is born in which to catch and to recover from any acute illness which can pass the placental barrier. During that period he may acquire—and not by inheritance—several chronic diseases. Also, the diseases of babyhood—that is, of his first two years of life—can, even though apparently well recovered from, affect profoundly his child's physical and mental development. The mental defects which now interest us may not become apparent until about nine years of life, or more than seven years after such injuries have been inflicted and forgotten. Yes, there is a real inheritance—the chromosome inheritance of the color of our eyes, of our hair, and the like. For illustration, I inherited the physical type of one of my grandparents. That is a chromosome inheritance which for the individual is unchangeable; it must be bred in or bred out during successive generations, if it is successfully to be modified. But I also inherited my great-great-grandfather's clock. That also was an inheritance. But that clock did not descend to me by the same mechanism of inheritance. I believe that the inheritance of feeblemindedness resembles that of the clock.

For illustration, many children are born with syphilis, a disease which can pass to the third generation, in each case contracted before birth, and yet the child, grandchild, and possibly great-grandchild did not "inherit" the disease. It is a matter of antenatal infection.

Again, in a goiterous region, the unborn child may develop a goiter, and that child's child be born a cretin. This defect, present in each case before birth, may be transmitted through an indefinite number of generations, yet it is not inherited. This is an illustration of antenatal nutritional disturbances.

Again, the little Irish boy talks with a brogue, and the Scotch boy with a "burr", and the little Chinaman, before he

is four years old, somehow or other naturally talks Chinese. He could have acquired a quick temper by the same method.

Another current belief which we would like to challenge is the fallacy suggested by the word "moron". If we were to ask you to define "moron", we feel sure that you would reply much as follows: an individual over twelve years old, who is physically normal (if a girl, you doubtless would add that she may even be very attractive) and who mentally would to a layman appear normal, but who, if tested by an expert, would be found to have the mental age of a child between nine and twelve years old. You doubtless would add that this feeblemindedness was transmitted according to Mendel's law; you would imply that this class is responsible for most of the crime and vice in the world; and you might end by suggesting a eugenics of cold steel. Am I not right? But this picture is not correct. There is no such secret army of enemies to society who can be discovered only by experts. True, there is a huge army of defectives in our schools, perhaps 400,000 in America alone, and a larger army of 500,000 not able to be in school at all, and only about one in ten of these in an institution. But we all know just who they are although we may call them by different names. No teacher with experience has any very great doubt concerning the identity of the majority of defectives in her classes; indeed we would trust her evaluation of their intelligence rather than the findings of a candidate for a master of arts in psychology who has just learned Binet's methods. It is in her philosophy of life, in her interpretations of these children that she differs from the psychologist. She and the psychologist have the same facts, but react to them differently. The ladies who rushed into a court to protest against the separation, urged by a child-welfare society, of three children from their feebleminded mother had no delusions as to that mother's mental ability; they had the same facts as the welfare workers, but a different philosophy. The judge who stayed a sentence to jail for a criminal in order that this convicted man might marry a none-too-bright girl before he began his sentence had no doubt as to the moral level of the man or of the mental level of the girl, and yet I doubt whether all the eugenists and specialists in psychometry could have altered his decision. The

judges need no psychologists to point out the simple-minded prisoners. They have the same facts; what the psychologists do is to give these facts a new interpretation. Another error merits challenge: the feebleminded group are not the criminals they are supposed to be. One confuses them with the unstable, the psychopathic, and the mildly insane; but they are a different problem. Neither are feebleminded girls a menace, provided normally minded men will give them as fair a chance as is given to their normally minded sisters. Indeed, reports of groups of feebleminded girls working in mills in the East show that their morals compare very well with those of others who are more fortunate.

The one question is, What will society do with this group? Mental hygienists insist that society—and this includes employers, teachers, and courts—recognize the limitations of defectives frankly and treat them as children of their mental age. We need no new laws. Those written years ago cover these cases completely. Why are they not enforced? We should establish guardianship over them, but not necessarily, or desirably, in colonies or in institutions. They make splendid mill operatives, splendid workers at simple tasks. The laws now forbid them to marry and state the penalty for those who abuse them. Why pass more laws to be enforced as poorly? We believe that only a small percentage really owe their defect to heredity and those few are so evidently defective that they need deceive none. Why complain of the feebleminded woman who returned to the county poor farm nine times in order each time to increase the population by one more idiot? All near her know that she is feebleminded; there can't be any mistake about that; they know that those children are feebleminded. Yes, and they know also who she says are the fathers of those children, and imbeciles seldom are bright enough to tell a good lie. Yes, they need mental hygiene in that county—surgery also, perhaps, but not for this poor imbecile woman. Such conspicuous cases are rare compared with the total number, but we have heard of that one woman until we are tired. Pass the eugenic laws now before your legislatures, treat radically all whom the courts allow you to, will that stop feeblemindedness? We believe that another generation would not know much, if any, differ-

ence, because the social mills would continue to grind out new ones. The children of the ill favored keep on in the environment of their fathers, in the same shacks, eating the same food, following the same examples set to each new baby, and, when older, repeating the sins of the fathers, not once, but often. The history of any defective family shows that we need not blame their state to heredity, since each generation seems to do its best to add to its unfortunate condition.

Concerning the insane, the message is much brighter and yet that is blue enough. Each year, 75,000 new cases are admitted to the American hospitals for the insane. There are, therefore, to-day, in the schools and colleges of this country, one million young persons who sooner or later will be so deranged mentally that they must be legally committed as insane. This number is large, but that of the number of persons who have the same diseases, but in so much milder form that commitment need not even be considered, is larger. And yet it is a conservative statement that one-half of these mental breakdowns could be prevented. One of the first lessons for the public to learn is that insanity is not a medical term—it is a social term, a legal term. Insanity is a term used of those mental disturbances of so marked a degree that legal measures are necessary for the protection of the patient and also of society. The term insanity has no reference to any one single mental disease; and each, if severe enough, can produce insanity. To illustrate, we would state that perhaps there is among the readers of this article a person with typhoid fever and certainly there are several with tuberculosis who do not know that they are sick, and who will get well without ever finding out that they have been sick. So there are doubtless several persons who have some slight mental illness, exactly the same illnesses that others have who are in hospitals for the insane. They may get well and without either their wives or their husbands or they themselves finding out that they have been ill. It is the degree and not the character of the disease that counts socially; it is the character and not the degree that counts medically. Society, however, does not quite agree with us. The laity object to our use of the term "insanity" for those mental disturbances which are due to well-recognized physical causes, such as

pneumonia, Bright's disease, brain tumors, or the effects of certain drugs, although persons afflicted with such mental disturbances may be just as wild, and their attacks on wife and children just as fatal, as those of the patient whom society calls insane. This means that the laity still believe in demoniacal possession.

Undoubtedly at least one-half of these cases of mental trouble could be prevented, were we able to put into effect certain very simple rules of living, which rules already are well understood. But since to follow them would mean certain important modifications in the lives of parents, certain reforms, our patients have no intention of putting them into effect. They prefer some unusual, novel, even forcible measures to correct this evil. We must correct it, however, and the following measures are among those necessary. Our medical schools should be provided with the proper hospitals in which to train students in the early diagnosis and treatment of mentally disturbed persons. There should be better wards in our city hospitals in which nervous persons may be treated without any more stigma of hospitalization than in the case of a patient with typhoid fever. Public-school teachers, particularly in the lower grades, should be specially trained persons who will be able to work with children in smaller groups and individually, not persons whose excellence is shown by their efficiency in discipline and drill. The great reform in the care of the insane and the prevention of insanity, however, will result not from new laws, not from new hospitals, but automatically as a result of education, which will raise the level of information with regard to these diseases and in that way create a new attitude toward, not only the insane, but the mental health of all fellow beings.

In addition to the groups already mentioned, with definite mental disturbances, mild or severe, but often temporary, is a more important group of persons who as long as they live are likely to have unfortunate urges, unfortunate inhibitions, antisocial tendencies, unstable emotions. These, on the one side, are the trouble makers of society, the zealots and fanatics, while on the other side are the discouraged and those who have a definite feeling of inferiority and are therefore unable to realize even their lesser hopes. It is to this group

of persons especially that mental hygiene offers assistance, not only to those who are already disturbed, but, more important still, to children, in whom we can prevent the development of such disturbances, as is now being done in the child-guidance clinics. The problems of labor unrest in so far as they concern the individuals involved, the problem of divorce, the problem of crime, all are to some extent problems of mental hygiene and to their solution the mental hygienist will make important contributions.

Mental hygiene has also a definite message for the normal man, for just as drill and wise coaching under a skilled teacher can improve one's game of golf or tennis, so mental coaching can and has changed an ordinary college football team into one of the victors. It is no ungrounded enthusiasm which prompts us to say that the man who is 50 per cent mentally efficient may hope to become 70 per cent, the man who is 70 per cent, 90 per cent, and so forth. It has been done.

In discussing this problem further, there are certain truths that deserve emphasis. First, the problems of mental instability and of genius are closely related. Protect a group of problem children and you are very likely to conserve a possible genius. Not that every problem child is a potential genius by any means, but potential geniuses, if not protected, are very apt to find themselves in the group of problem children. Those with nervous systems so well balanced that nothing seems to disturb them seldom have much inspiration or talent. Their lives seldom rise above a dead level. They carry by far the heaviest burdens of the world; they seldom get spoiled. Too many of our geniuses do. No, we do not mean that our jails are full of geniuses. In the Middle Ages that may have been the case, but not now. Also, do not understand me to imply that a person shows his instability and his maladjustments best by antisocial attitudes. Some are reckoned as blessed reformers. In part, attitude is a question of direction, and to the psychiatrist the difference between many a saint and many a sinner is only the small difference of direction.

Secondly, fear, apprehension, and the like are paralyzing emotions which inhibit and lessen power of action and in time

alter the very mechanism of will and the very physical organs of motion.

Third, society seldom appreciates the importance of nutritional conditions and the relation between mental states and physical diseases. Under-nutrition and mental stability cannot go together. Sooner or later the undernourished person becomes unstable, often resentful and destructive. History is full of stories of the ruthless fury of hungry mobs. You avoid petting a hungry strange dog or cat; he is restless and irritable. But give him a good meal and later he is more friendly. I am not speaking merely of those who are underfed and hungry, but of those who are definitely undernourished because they desire no more than the too little that they do eat and who too often are proud of their abstemiousness, and also of those who may eat enough, but who, for various physical reasons, are unable to use the food that they ingest. Whatever the reason, under-nutrition causes fairly definite mental states. In the undernourished group are many unstable, undependable, unreliable persons; persons unreasonable in their zeal for reform; persons consumed with desire to help their fellow man, and others as willing to hurt him. Do not misunderstand me—we do not for one moment ascribe all such emotions to undernourishment, but we do assert that undernourishment tends definitely to intensify such emotions in man. The genius of Shakespeare inspired him to express a lack of confidence in a man with a lean and hungry look. I am informed by one in a position to know that one of our great allied countries refuses to appoint to its secret service a thin person. Not that all thin persons are undernourished and therefore undesirable, for many inherit that physical build, but since among those who are underweight there may be those who are distinctly undernourished, this particular nation does not take a chance with any, fearing that such a man may not be quite as steady, quite as reliable, quite as trustworthy, quite as dependable for long periods under trying conditions as the secret service demands. In the treatment of mental disturbances we see this clearly, for nothing quiets the restless maniac, helps the worried, or brings sleep to the nervous like overfeeding.

The next point we would emphasize is the importance of

those latent, often undiscovered, physical diseases which may give no direct evidence of their presence, and yet which, by influencing body growth, limiting the functional ability of the various important organs, and lessening the sum total of strength, influence powerfully our emotional life. They hinder us in the realization of our ambitions. They help to cause hostile attitudes toward life. They affect our work, our social life, and even our religion. We refer especially to chronic tuberculosis, which may smoulder for years; to the undiscovered syphilis which for decades secretly, but steadily destroys important tissues; to slight heart weaknesses, which explain why a boy does not excel in, or enjoy, physical sports; to latent kidney troubles; and other chronic diseases.

The chief symptom that such diseases cause is easy fatigability, and fatigue always narrows the mental horizon, limits definitely the scope of the field of the associative memories, reduces the stimulating power of imagination, and as a result hinders the individual from realizing his ambitions, whether in work, play, or in his social life. The individual seldom realizes what the real trouble is; certainly he seldom believes that it is in himself. Why should he? He does not know how other boys feel. The result is that he interprets his failures to be promoted, his lack of success in life, as due to the hostility of others. So he either assumes an antisocial attitude and tries "to get back at" society—thus becoming a trouble maker or even a criminal—or he develops a complex of inferiority and so becomes more a weakling than he really should be.

But the story does not end here. The resulting hyper-tense emotional states of worry, anxiety, and resentment, if continued too long, themselves help to bring on physical diseases. They become an important, although never the sole, cause of high blood pressure and of various thyroid disturbances, causing first hyperfunction, therefore—in part at least—exophthalmic goiter, and, later, as a result of continued fatigue of this gland, myxedema. These diseases again become efficient links in the causation of still other diseases which are better known, especially hardening of the arteries, and various heart, liver, and kidney troubles. The same emotional states are partly responsible also for the production of

both varieties of diabetes; and, finally, they are very potent determiners of the degree of immunity production when a man is in the presence of the infectious fevers—for example, pneumonia—their presence or absence alone sometimes determining the fate of the patient. The so-called "virulence" of a germ of any given variety depends not so much on its own inherent qualities as on the susceptibility of the person harboring it. For example, when an epidemic of measles or of scarlet fever spreads in a school population, some children have the disease and never know it; some remain home from school for a few days; others die. How each child responds depends not on the severity of the case from which he caught his illness, not much on the virulence of the germ, but on his own biological resistance; and this in turn depends partly on his own past history and more on the past history of his ancestors. Eliminate disease? Do you realize what that means? Eliminate disease? That slogan of so many health campaigns so glibly repeated and so vociferously proclaimed? Is it possible? If possible, is it desirable? Even those of you who believe in a six-day creation realize that man was born into a world already inhabited by plant and animal kingdoms and that he conquered not only by the sweat of his brow, but also by his ability to establish immunities. Thus, against great odds, he fought his way to a state of self-preserving strength. Eliminate disease? Would you eliminate the practice games of a football eleven? Would you prevent a child from exercise for fear that he might get hurt? No, it is by the practice games that we gain that strength and skill necessary to win out in the more serious games. Indeed, I cannot conceive of a more unfortunate individual than a child so protected against diseases that he has gained no immunity against them. The chances are that he will succumb to one of a trivial character. We need our practice games. We need biological as well as muscular exercise. Fortunately of most of these practice games we are quite unconscious. The immunity that the child receives from an attack of scarlet fever so mild that he had neither fever nor a scarlet rash is in every way as strong, and perhaps stronger, than that of the child who barely recovered. We would at this point add also that the better vaccinations are nothing more than practice games,

but so staged that the child develops his immunity with a minimum of danger. The above may seem like a digression, but the conclusion is that the acute infections and the chronic degenerative diseases are indissolubly bound together, not so much in the same individual as in his family; and that while the mental states and physical diseases, both acute and chronic, are inseparably bound together in the chains of causation, yet on the whole the mental element seems rather fundamental.

The assumption is often made that the problems of the individual are identical with those of the family, but we of "cold-blooded science" attach great importance to those words written over four thousand years ago—"visiting the iniquity of the fathers upon the children unto the third and fourth generations of them that hate Me", and also to those words spoken to a race and not to separate individuals, "If thou wilt not observe to do the words which I this day command thee, then will I bring upon thee the disease of Egypt of which thou wast afraid." In other words, the moral, and by that we mean the mental, problems of one generation become the physical problems of the next, and both must be treated separately. The boys who were wounded in the past great war were not at all to blame for the sequence of political—that is, of moral—that is, of mental—events which led up to that great war, and yet they suffered, and you insist that each receive kind and efficient individual care. So the unfortunate boy or girl of to-day with a mental defect for which he or she is not at all responsible deserves kind and skillful consideration. The campaign to prevent the production of more such victims must be one of social readjustments and altered mental attitudes. A moral reform, yes, but by that we mean a mental reform, and by that we mean a reform based on scientific psychiatry and sociology as applied to the family group. We do not mean an ignorant, depraved, sadistic, cruel eugenics.

We of the mental-hygiene group have no therapeutic panacea for the relief of the mental deficiency and mental diseases that give you so much concern, neither do we warn you of any imminent dangers that may seem to impend. We do not urge any program of radical reform, but rather one of research,

education, and demonstration. The mental hygiene we would offer is not alone for the defective and unfortunate, but also, and primarily, for those who, proud of their mental strength, are impatient of the weaknesses of others which they do not understand and yet which concern them primarily and vitally. The first step in the solution of this great social problem is not a coercive social reform, but the arousing of an enlightened social conscience.

PROGRAM FOR MEETING PSYCHIATRIC NEEDS IN THE CITY

AIMS AND PROBLEMS OF THE CLEVELAND PLAN *

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IT IS not my intention in this paper to try to present a program for meeting *all* the psychiatric needs of a city, but to outline a plan for meeting some of the needs that are not now commonly met. A basic need in any program is, of course, the provision of facilities for the recognition and care of the feebleminded and insane, in the legal sense of those terms. This involves adequate diagnostic service, to be had in Cleveland in a variety of ways—from practicing psychiatrists, hospital-dispensary services, and the psychopathic hospital. Care and treatment must also be provided, either in special institutions, private or public, or in the community. All of this work centers around the treatment of disease and defect states, while our interest to-day is in prevention rather than cure. For that reason we shall not further discuss this important phase of the work, but will devote attention to the problems involved in a preventive program.

By common agreement a preventive program must be focused upon the problems of children. The main reason for this is that we know that work with children, when attitudes and personality trends are developing and before modes of response have become fixed, will prevent a great many difficulties both in personality adjustment and in behavior, and will, therefore, contribute to a happy and healthy life. It is clear, however, that working with the problems of children involves also working with the problems of the adults who control in so many ways the life and development of children. We have, then, actually a double approach in our preventive work, working with both the child and the adult to achieve for

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each new levels of adjustment which shall be reflected in the relations between the two.

There are many known groups of children who present problems for mental-hygiene work. There is the group of dependent children, who, because of some disaster in the home, are becoming social charges and will during the period of childhood have their lives ordered by the social agencies, institutions, and foster homes that assume the responsibility for them. For these a mental-health study seems needed, in order that really adequate plans may be made for their care. The mere fact of the breaking up of a home, and the necessary assumption, by some extra-home agency, of the care and training of these children, presents a mental-hygiene problem of no small proportions in the individual child.

There is also a group of children who show retardation in intellectual development such that they are unable to compete in the ordinary types of intellectual work required of them. The need here is for adequate diagnostic facilities in the schools, and over and above that, adequate facilities for the proper education of those children who are unable to keep up in normal competition and also for the superior child. It is to-day recognized as a basic principle in mass education that classification of pupils according to intellectual ability and the provision of special types of education is an essential not only in training for economic productivity, but in procuring an adequate degree of stabilization for the individual child. As is true in any section of our work, the facilities for diagnosis are not enough. It is much more important to have developed methods of dealing with the diagnosed cases than it is *merely* to make the diagnosis. I should plead here for a complete obliteration of the notion that just because a diagnosis has been made, the situation has been in some way helped. To be sure, adequate planning and adequate treatment cannot proceed until there is an adequate diagnosis, but the diagnosis is not an end in itself; it is only a means to the end of proper treatment.

There is a third group of children who present problems in behavior ranging all the way from mild to grave, and involving such groups as the home, the school, or the community. The home problem is ordinarily handled by the parents, and

as a general rule very little admission is made outside the home that a problem exists. It is true that often parents handle such problems unwisely, and they often handle them too impulsively. They make mistakes in many ways in meeting the issues that are raised, but, after all, these problems belong to them and they are the people who must meet them, whether they meet them well or poorly. It is not fair to criticize the parent for meeting the problem poorly when the parent is giving to the solution of the problem the best that he knows. Evolution of assistance to the parent in meeting such problems has come about in various ways. Indeed the very variety of methods has operated as a handicap to securing a better level of parental care. For the most part parental education has been based on an external and superficial type of approach, the problem having been viewed entirely as an intellectual one, and handled on the presumption that a presentation of the facts would clear up the situation between parent and child. Unfortunately parents are people, and, being people, they have emotional blocks, pathological attitudes, and inner strivings of their own to which they react in dealing with their children. The presentation of intellectually graspable material will not succeed in altering the parents' point of view and methods of dealing with the child, if that material does not reach their emotional blocks and help to clear up their own prejudices. Imposed education will never do this. Only the education that develops from within, that meets the issues presented by the individual personality, will ever succeed as a real preventive measure in dealing with parents.

The school has developed a great many types of machinery for dealing with the behavior group. There are special schools of certain sorts, often handicapped in the very good work they are doing by being classed as the "Bad Boys' School" or the "Bad Girls' School", attendance departments, truant officers, parental schools, and the like. But all too frequently this machinery is again superficial and external in its approach, viewing the child who breaks the rules of the school as a case of difficult behavior rather than as a living, adjusting organism whose behavior is but a blind expression of difficulties in adjustment within the individual or between

the individual and his social nexus. This is perhaps an expression of a universal tendency that is even more marked when we view the attitude of society to those who do not conform in their behavior. Ever fearful, the social group is quick to take steps for its own protection, and what boots it that this protection in and of itself frequently does the opposite of what the group is really striving for, and merely produces a more serious type of offender? I take it that our expressed social purpose is to have a happy, healthy, and harmonious group. It is, however, a fair criticism that we as individuals want the health and happiness and expect the other fellow to provide the harmony, and in case he does not, our immediate protective reaction is to exclude him from the group. We do not consider enough the point that perhaps we, too, have contributed to the disharmony and that perhaps we, too, are partially involved in the other fellow's failure to adapt to the group. This method of exclusion from the group or the tribe, whether it be by death, by deportation, by imprisonment, or by slavery, is the most primitive of all the group responses to the individual who disturbs the peace, the security, or the comfort of the group. That the method is not in and of itself constructive is no bar to its application. That it does not succeed in producing a viable social unit from our misfit will not interfere with its application because it is based on some of the strongest primitive emotional reactions that individuals have. After all, the group is composed only of individuals.

We have, therefore, in the work with the children who present behavior problems, community resistances to overcome. There is apt to be a strong community feeling that people are bad or good according to their heredity or their environment or their own voluntary choice, and we seem to have a community feeling that we should react to them only as they are of their own volition good or bad. There is a further community attitude concerning those who attempt to study problems in behavior with the same objective attitude and the same patient search for facts, the same patient attempt at the evolution of methods for dealing with those individuals who do not conform, that characterize the growth of any body of scientific knowledge. Such groups are often

regarded as queer or Bolsheviks or sentimentalists or enemies to the established social order, and so forth. Not much of this antagonism finds conscious expression, but enough comes out from time to time to indicate what the trend of community thinking is. People who try to work with behavior problems are accused, on the one hand, of being arrant sentimentalists, and on the other of being too scientific and inhuman in their approach. They are accused, on the one hand, of trying to standardize all children, and, on the other, of making individualists of the children with whom they deal. They are accused of publicity seeking, and of not doing enough publicity; of not doing enough follow-up on cases and of making too much study of a case. This list of ambivalent criticisms could be extended almost indefinitely. Actually they prove only one thing, which is that the groups working with behavior problems are approaching these problems objectively and scientifically, with sympathy for all the individuals who are involved in the difficulties, without expressing the revenge motive which is so characteristic in the social approach to behavior problems, and with an absence of predetermined judgments. In other words, these criticisms prove that these groups are doing their job as it should be done and not according to the emotional will-of-the-wisps that determine the attitude of the critics.

We have, then, three general streams of cases ready made. This must not blind us to the fact that it is not only these three groups—the dependents, those who are failing in competition in the schools, and those who present problems in behavior in home and school and community—who are mental-hygiene problems. There are also the ordinary normal children in the ordinary normal homes, who have problems within themselves and in their personal relationships that deserve some of our time and attention if our idea is the greatest possible mental health for the greatest possible number of people.

In any organization for mental-hygiene work in a community, there are four fundamentals that must be recognized.

First, it is necessary to realize that mental hygiene is not the job of any one group in the community. It has been well said that mental hygiene begins at home, and a canny epigram-

matist once added, "and often should stay there". Mental hygiene as such, having to do with that portion of the organism that expresses itself in social relationships, is in some sense the job of each one of us. Scattered principles of mental hygiene are to be found in the written records of all civilizations. Their formulation into a definite or fairly definite set of principles is, however, a matter of very recent times. What the mental-hygiene movement is trying to do is to formulate in scientific fashion the rules of mental health and the ways and means by which mental health may be gained or increased. Mental hygiene is an important factor in the life of every one who has to deal with children's problems. It begins, or should begin, with the problems of one's own mental attitudes as they affect one's relations with others. It extends in ever-widening circles from these people who make their own mental hygiene a definite objective. To mental hygiene and its principles contributions have come and will come from a wide variety of different sources. The most important contributions have been made by the overlapping fields of psychiatry and psychology, which have formulated, respectively, the facts about mental disorders of all sorts and the facts about the normal mind. Mental-hygiene leadership is to be expected from this group, but mental hygiene as a job is not the job solely of this group. These two and social work, education, recreation, the home, the school, the church, and the court—and so on through a long list of community resources—have each something to contribute. Sound mental-hygiene work, to reach any considerable portion of the community, must, then, be well organized, receiving contributions from all those zones of work that may be expected to make contributions and making contributions to the working techniques of the groups who deal with large groups of children.

The second fundamental is that the number of trained and experienced workers is limited, and this condition, as I see it, is bound to continue for a considerable period of time. The personnel is increasing constantly, but it is not increasing in proportion to the increased demand. Such personnel as we have available must be used in terms of leadership. A warning seems necessary here: half-baked mental-hygiene work is probably much worse than no mental-hygiene work at all,

and a trained and inspiring leadership is absolutely essential if adequate work is to be done in the community. Above all things, sentimentalism as a stimulus to mental-hygiene work is to be deplored, although sympathy, human understanding, and tolerance are outstanding needs for any sort of mental-hygiene work.

The third fundamental is that the community has a large inertia. Man's primary interests lie in the preservation of his life and in his physical comfort. The mind remains for most people the greatest mystery of all, more secret and, in a sense, more sacred than reproduction itself. The general ideas of the mind adhere to archaic patterns now worn threadbare, and it is an enormous problem and an enormous task to present newer conceptions of the mind in a way that shall be workably related to the individual and his concepts and his job. We are, on the whole, mentally lazy. We object to new ideas, we object to anything that disputes the ordered series of concepts with which we placidly face the difficult problems of existence. Anything that affects our feeling of security in ourselves is rejected, and all these elements enter into community inertia. As a group, we act only when fear of some sort is aroused. The mental hygienist does not wish to use fear as a means of arousing people to action because he knows its detrimental effects all too well. We are, then, faced with the problem of patiently trying to dent an inert mass, and oftentimes our efforts seem all too puny.

The fourth fundamental is that our basic knowledge, despite all that we know, is still limited and that we have not reached a stage where we may sit back and formulate final and static rules to cover all the mental-hygiene issues. Quite fortunately, we never shall be able to do so, because our problem is not a static problem, not a question of structures to be analyzed, but is a problem in dynamics, in dealing with which we are confronted by constant flux and change. We shall need to keep up a constant stream of educational and clinical work if we are to succeed in our mental-hygiene efforts.

With all these points in mind, it becomes possible to sketch the broad outlines of the organization of a community for mental-hygiene work. The plan here presented is necessarily an elastic one, since so much depends upon the facilities avail-

able in a given community. Perhaps no community is at the present time in a position such that a complete organization of this type is possible, and certainly many smaller communities could deal only with one or two elements of the plan. There is no reason, however, why a community should not start something commensurate with its facilities and its needs, even though only a small part of the needed work were attempted in the beginning.

The central feature of organization for mental-hygiene work, as I see it, is clinical work with the groups of children already outlined. There are several conceivable ways in which this could be done. The most satisfactory method, in my opinion, is that of the central independent clinic group whose services are available to social agencies, schools, courts, physicians and hospitals, and parents. This method of organization is preferable to the method of organizing a series of clinics to serve these agencies individually. Such a central clinic should be staffed with psychiatrists, psychologists, psychiatric social workers, and the needed clerical group, in order to make effective its clinical service and in order to develop that degree of community coöperation which is absolutely essential in work with maladjusted children. In individual instances, communities have set up such clinics in relationship to some specific agency dealing with children, as, for example, the clinic in the public schools in Minneapolis, the various court clinics, and so forth. From a practical point of view, however, if one accepts, as I do, the central principle that the clinic is a coördinating, coöperating center and that it must establish broad lines of coöperation with all the institutions, including the home, that enter into and affect the life of the child, the desirability of an independent organization and position seems quite clear. Properly organized and with a large enough staff to care for the work, there are several types of clinical service that may be offered.

First, there is the mental-health study for dependent children who are becoming charges of the social agencies of the community. We have long ago seen the light on the advantage of studying the physical health of the child at the time when he becomes a public charge and providing care and treatment for the minor and major physical defects that may be

found. In many communities a further step has been taken and the intelligence of the child has been measured at the time of his admission to the agency, for the particular purpose of selecting the feebleminded children who should receive care in a specialized institution. So far as I know, there are no communities that go beyond this and round out the study of their children by looking into other matters concerning mental make-up and mental health. Since we recognize more clearly to-day than ever before that other aspects of mind than intelligence are of the greatest importance in determining healthful social relationships and the successful living of life, it would seem entirely logical to develop a completely rounded study of the mental health of the child at the time when he becomes the charge of a public agency rather than after he has given indications of the need for study of his mental health by presenting problems in behavior or in other ways. The proper formulation of this mental-health study is an issue of grave importance, as there are so many ways in which it may be wrongly or poorly done and so be a hindrance rather than a help.

The second type of service would be a consultation service designed to evaluate situations with which case-workers are confronted in the management of their case-work problems. In this instance, the consultation is based on the worker's record and accumulation of data rather than upon individual study of the child. We must, it seems to me, constantly bear in mind that this method has great limitations, and that it is in no sense a substitute for actual study of the case. Nevertheless, it is an important and helpful method so far as the case-worker herself is concerned. On the basis of an experiment carried out last summer, we have had a workers' consultation service with three agencies during the past winter, and it seems to me that it has been highly successful in achieving its objectives. These are a provision of definite help to the worker in dealing with her immediate problems, adding to her knowledge of mental hygiene a technique and principles which she can apply to other problems with which she is confronted in her case-work, and increasing the effectiveness of the coöperation between the clinic and other agencies. Many of the cases presented in such a service must necessarily be

studied in detail before any satisfactory solution of the problem is reached.

There is another small group of cases which can be dealt with on the basis of advice directly to the parent who is having difficulties with a child. Such cases are not numerous and must always be very carefully and critically selected for such management. They are represented chiefly by instances where a parent has become, perhaps suddenly, quite apprehensive concerning some minor trait which the child shows, and desires advice as to dealing with the immediate situation. A fairly careful survey of the situation with the parent will usually show whether a complete study is necessary.

Another type of service is the one of partial examination in cases in which the preliminary statement of the problem that the child presents is fairly clearly indicative of the nature of the underlying difficulty, and one or more special examinations are necessary to confirm or refute this first impression. This type of service seems most profitable in the examination of children when feeblemindedness is suspected, and the intelligence tests give a clear-cut answer to the question. I do not mean to imply that only the intelligence tests should be made, since other factors may enter into the problem as well.

These shorter services—or, as they are commonly called, slight services—are the most difficult of all with which to deal, and demand from the staff members working with them the highest degree of alertness, quickness, and skill in interpretation. In our experience, they are not services to be intrusted to those who are just beginning their work in this field, but rather to the most experienced members of the staff. It must always be remembered that they are, after all, only first approaches to the problem and that no cases should be dealt with by such slight services unless it is absolutely clear that a contribution can be made in this way to the treatment of the situation.

We come, then, to the major clinical service of such a clinic group—namely, the complete study and evaluation of a situation, its interpretation in terms of the dynamic stresses and strains involved in causation, and particularly the carrying out of treatment measures designed to remedy the fundamental difficulties in the situation. I would emphasize again that

making such a study is not in and of itself enough, but the study must be *functionally useful* and *used* in the treatment of the problems presented, else it has failed. I take it I need not repeat the fundamental studies involved, but I should like to remind you that when we deal with a human being who is out of adjustment, it becomes absolutely essential to study all of the ways in which he is out of adjustment, all of the ways in which he is well adjusted, all of the underlying factors in his personality that contribute to the lack of adjustment, and all of the factors in his environment—with particular reference to those dynamic portions of the environment, the personalities to whom he must adjust—before we can be very certain of the steps to be taken in readjustment.

It is, in my opinion, a mistake for such a clinical group to attempt to carry under treatment any considerable proportion of the cases it studies. To do so would not only reduce its opportunities to deal with the constantly increasing stream of cases that the community sends to it, but would prevent the development in other agencies of their own treatment attack and of their use and understanding of mental-hygiene principles in their own work. Wherever possible, it is clearly desirable to carry on treatment measures coöperatively, the agency of primary responsibility for the child carrying out the social-manipulative measures, the clinic carrying on the more technical psychotherapeutic measures. The bulk of the clinic's cases should always be, it seems to me, those which we call consultation cases, meaning thereby that after the study a report and recommendations are given to the agency of primary responsibility and further contacts are made by the clinic to follow up and see what the outcome of the situation has been, or on request of the agency as new situations arise. To make this consultation service effective, it is necessary to have a very clear understanding between the agency and the clinic, and there must be constantly developing a greater and greater realization of each other's problems, points of view, technique, attitudes, and vocabulary, so that the report to the agency will have meaning in terms of functional effectiveness. Because of the ease with which this can be started, the point is often overlooked that to make it effective demands a great deal of careful, patient, slow work,

not only in this particular field of agency and clinic contacts, but in many others, and that the desired results are not to be obtained in a day. The most necessary item for it seems to be that the clinic shall not pursue a policy of splendid isolation, but shall actually be integrating itself into the work of the agencies to which it gives service.

Our clinic staff, then, must provide for the community both direct and indirect case services, which shall be functionally useful to those whose continuous contacts with the life of the child are so important in shaping the individual into which the child will develop. In the Cleveland plan, both of these direct and indirect services are provided for, and as the plan stands at present, there would be, for all children coming into the hands of social agencies for a long-time placement, a routine mental-health study with a report to the agency, but with no assumption of responsibility for the final plan on the part of the clinic. It would give to the educational system, agencies, and court a problem service concerned with the study of children who present known problems in adjustment and the development of the treatment of such defects. We hope to provide for the court a special sort of routine mental-health survey through which cases would be chosen for more intensive study and treatment in coöperation with the probation staff.

We have come to the conclusion that there is a definite technique in the setting up of adequate coöperative relationships with another agency. This technique, in our opinion, involves three steps. The first step consists of lectures or group discussion through which the mental-hygiene principles involved in work with children may be presented to the entire staff of the agencies with whom one wishes to work. If this is a very large staff, this preliminary work should be done with the supervisory group, since through them all of the case-workers in that agency may be effectively reached. It will be necessary also to develop in the agency one or more workers who, through some six months of assisting at the clinic, become completely familiar with it and acquire a great deal of information concerning mental-hygiene principles as applied to their own field.

The second step, then, in the evolution of coöperation is the provision either of the mental-health-study type of service or

the workers' consultation service, through either of which further diffusion of mental-hygiene principles and technique becomes possible. Not only does this result, but the clinic staff itself becomes increasingly familiar with the problems and technique of the agencies with which coöperation is established.

The third step is the actual coöperative study and treatment of individual cases. Of course these three steps are often going forward simultaneously.

It is clear that in the clinical services, as outlined so far, there is constantly being carried forward a mutual education between agencies and clinic which in the long run increases the effectiveness of clinic work and adds to its case-load capacity. It is, perhaps, not possible in any community, and has not been possible here, to develop these coöperative services with all the agencies that might use them. It has recently been pointed out that we have done far too little work with the settlement houses, with the recreation workers, and with the orphanages, yet until satisfactory coöperative work with case-working agencies, the court, and the special divisions of the schools has been established, it is impossible to do very much with the other groups, and in a community plan I would not advise trying to reach all of the groups at once, but, instead, attempting to reach first those groups with which satisfactory working relationships are the most important.

Beyond these clinical services, there is the large issue of education, which means primarily the education of adults with regard to mental hygiene and with regard to the children with whom they must deal. It is imperative to recognize the need for a carefully laid plan for such educational work, else the drain upon the time and energy of the staff may seriously interfere with its central objective. There is a great appeal to the individual in being invited to address a women's club or a men's club of importance and standing in the town. Such invitations are apt to be so numerous that they become a serious problem. Organization is necessary in advance if the work is really to be effective. As a group, we have discarded the single-lecture idea as a means of really contributing to the mental-hygiene education of the community. It is useful and

we use it and we try to make our single lectures as educational as possible, but we do not rely on it and regard it as wasteful. Instead, we have steadily pursued the policy of arranging for talks in series to be given to groups of organizations, such as Parent-Teacher associations, in such a way that we reach a great many more organizations and reach them more effectively than if we went to each with a single talk. This is the explanation of the fact that in the past one and a half winters we have been able to reach all but 56 of the 140 odd Parent-Teacher associations in Cleveland and its immediate suburbs, and that there is no important woman's club in the city of Cleveland that has not been reached in some way. The problem that now confronts the community clinic is, on the basis of this broad foundation, to do a more definitely educational job in such a way that a considerable group of people will be reached and yet the time of the staff conserved. So far as the plan has been evolved, there would be during the coming winter a series of from sixteen to twenty lectures to one large group of mothers. Realizing as I do the unsatisfactory nature of the lecture as a means of mental-hygiene education, it is further planned to split this large group into small groups of twenty, with a leader for each. The person who gives the lectures will afterwards meet with the group leaders for a round-table discussion of the material presented in the lecture, and each leader will then have a round table with her group of twenty to discuss the lecture and relate the material thereof definitely to the problems of the people in the group. From what I know of the Cleveland public and of the group of women who, as a subcommittee of our board of trustees, have evolved this plan, there is no reason to doubt that such a series will be largely attended and will have a pronounced effect upon the community attitude toward children and their problems.

So far we have been speaking only of parents. The parents are not the only group in the community for whom educational work must be provided. The next largest group of people who come intimately and constantly in contact with children is the group of teachers, and here we are confronted with two issues. First, there is the teacher in the classroom, daily confronted with the problems in adjustment and behavior of the

children, harried and torn by the demands of her job. This teacher has needs, which she recognizes, for mental-hygiene principles and technique in her work. Then there is the teacher in training who is soon to be confronted by these same problems that harass the teacher in the classroom, and means must be found for reaching this group as well. Then there are the social workers—those in the field and those in training, particularly the latter—and various other student groups that should be reached had we the time and the opportunity. Particularly courses for medical students seem imperative, if medicine is to make its proper contribution to the whole field. For education and for social service, definite courses have been and will be given in the schools of education and of applied social science at Western Reserve, which has many advantages for students and clinic staff. The method of the formal course is time-conserving for the staff and reaches a large group in an orderly fashion, at the same time giving the students university credit. It should be pointed out that other courses in mental hygiene and child training are available—such as the course for parents given by Professor Myers at Western Reserve—and that the clinic group is greatly interested in stimulating attendance at these courses and in increasing the number that are available. In other words, the clinic does not compete with established work, but attempts merely to supplement it by courses dealing with the special phase of behavior presented chiefly from that clinical point of view which is so essential in mental-hygiene education.

To carry out all this work in the community demands a high-grade, stable organization as a background for these clinical workers. In Cleveland this organization will probably be an independent board of trustees appointed in part by the Welfare Federation and in part by the board of trustees of the Children's Aid Society. Our present board, by its own vote, automatically expires on February 1, 1927. The new board will probably follow along the lines laid down in the make-up of the present board, which includes a wide representation from the board of education, the parochial schools, the juvenile court, the several women's clubs, the Parent-Teacher Council, the Welfare Federation, the Jewish Welfare Federation, the Cleveland Foundation, the Board of Trustees

of the Children's Aid Society, the federated churches, the Academy of Medicine, several departments of Western Reserve University, and the boards of a number of coöperating organizations. There is a principle involved in the selection of such a board, which is that it should be widely representative of community interests, and particularly should there be an interlocking directorate. Not only should the board stand for something in the community, but it should stand for something in the clinic, and it is imperative that such a board should be well informed regarding the operations of the clinic, for which reason a series of standing committees should be constantly at work.

With such an organization of board and of clinic, with constant interchange between the two, with clinical and educational services provided, with constant upbuilding of coöperation with other agencies and constant resistance against the common trends toward isolation and jealousy, it seems to me that the community is organized so that mental-hygiene work may go effectively forward and help, as it undoubtedly can, in procuring for the individuals in the community a better mental health than they already have, and so increase "community mental health".

EMOTIONAL HANDICAPS TO INTELLECTUAL ACHIEVEMENT IN SUPERNORMAL CHILDREN*

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IT IS becoming a recognized principle among educators that, in establishing the intellectual capacity of an individual pupil, we have answered only one of many important problems. For a time, knowledge of mental ability sufficed for classification in schools, until, with the development of interest in the other aspects of human mental life, it was found imperative, for the adequate handling of educational problems as well as of obvious behavior difficulties, not only to know the pupil's score in a standardized test, but also to understand his personal relationships, attitudes, and feelings. The desire for such additional information grew up in part because of the heavy toll of unexpected and unwarranted failures in achievement. Such failure is a phenomenon common to all grades of intelligence and to all ages, but it is perhaps most serious when it occurs among gifted children, since it is to them that the world must look for its progress. How often has the sceptical and practical layman asked, "What happens to all these brilliant children when they grow up?" And no doubt the answer is, "Many of those we never hear of again belong to the emotionally handicapped who never, because of their social unadjustment, reach the full promise of their potentialities."

It is with this group that we are concerned, singling them out because of the alarming proportions of the problem, partly the result of our educational policies and still more of social unadjustments. We are ignoring, for the present discussion, consideration of those who are highly endowed with special abilities or handicapped by special disabilities, taking supernormal in the technical psychological sense to mean children

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who are equipped with all-round mental ability, as judged by the Terman revision of the Binet-Simon test, at least 10 per cent above their chronological ages.[1] That is, they have intelligence quotients of 110 or more, yet are failing in school, are disproportionately retarded in grade placement for their mental ages or actually retarded for their chronological ages, or show by retesting that estimates of their native intelligence suffer severely under the strain of emotional problems.

Should any one doubt the necessity of devoting special attention to this group of unwarranted school failures, there are some enlightening figures to be obtained from the records of the Bureau of Children's Guidance, which, though at present in rough statistical form, indicate conclusively a real problem. About ninety, or 15 per cent, of the cases referred to the bureau since its establishment four and a half years ago are in the supernormal group. With eight exceptions, they have been referred as manifesting undesirable behavior symptoms, but, in addition, thirty, or one-third of the group, are reported also to be failing in one or more school subjects, some in all of their class work. Instead of being advanced for their chronological ages, or at least normally placed, we find 20 per cent of the group over age for their grades. We must look then for demotions—ruling out late entrance in each case—and we find that as many pupils were demoted as were over age. Occasionally a gifted child was found to have had as many as four demotions, and rarely has such a pupil advanced rapidly enough to make up the lost time. Ordinarily one expects supernormal children to derive satisfaction from school success and to exhibit considerable interest in academic activities. When one finds as large a showing of failures as this, one must look for the causative factors that lie back of the unadjustment, to learn what is giving some of our gifted children more satisfaction than successful use of their intellectual equipment. We find the most significant answer in the compensatory or protective mechanisms which the child employs in his educational maladjustment. Further

[1] Wherever in this paper a child is designated as supernormal because of his intelligence quotient, it is to be assumed that the psychological examination revealed nothing to indicate either special abilities or special disablities. A full discussion of the problem would include those cases also.

investigation leads us to the home or school setting which makes possible the use of the undesirable reaction instead of the healthy one. At this point, perhaps, it is well to recognize that many school *successes* are experienced unhealthily through the infantile desire to please, or as an escape from heavier responsibilities; but we will discuss in detail only the reaction of *failure* to achieve.

Though this problem arises at all periods of school life, from our experience with this group of supernormal children there appear to be three strategic points: first, the time of admission to elementary school, whether to kindergarten or first grade; then entrance into junior high school; and, third, admission to first-term senior high school immediately after graduation from the eighth grade. It may rightly be argued that for any child these occasions mean a tearing loose from old conditions and a readjustment to a setting that demands increased responsibilities. Entrance to elementary school represents the first separation from a protective home setting, a bewildering contact with a large group, the first assumption of independent duties. Junior high school supposedly is a gradual change from the close supervision of primary school, not so complete a change as senior high school. We find, however, that it reacts on many pupils as a revolutionary experience if we are properly evaluating their inability to meet the new responsibilities of departmental administration. The shift from a single teacher, who is easily placed in a parental rôle because of her close contact and more intimate knowledge of her pupils, to a comparatively unstable, varying group of subject teachers, who handle several hundred children a day and therefore have close connections with none, requires not a gradual change of attitude, but a sudden assumption of the independent rôle.

If we stop to consider that often, from the time of admission to school, the supernormal child is exposed to competition with older children, emotionally more mature than himself, it is clear why at these strategic points he seems strangely unable to adjust. He has not attained that stage of emotional development which permits him to meet the new social-educational situation with the ease possessed by his older classmates. The normal pupil of twelve enters junior high school

with some pre-adolescent leanings toward emancipation, whereas your ten-year-old, in the same placement because of his rapid advancement, is completely at sea. His disturbance is manifested not only in his behavior, but in his work. This is the point at which his marks take a slump. The same is true of the twelve-year-old gifted children who enter senior high school in competition with their fourteen-year-old classmates. Whatever difficulties lie before the average pupil when he is transferred to a new setting are intensified threefold for the younger, more immature, though highly gifted child.

Achievement, as we take it, includes any intellectual performance for which the psychologist or teacher is using an objective measure. Such use of the term includes certain measures less objective than the intelligence and educational tests which are the instruments of the clinical psychologist—namely, the grade placement and class ratings, both of which are subject to the judgment of individual teachers and to school policy. Nevertheless, it is absolutely necessary to use these rankings as measures of success or failure, in spite of the fact that grade placement depends on the attitude of the school board toward advancement or retardation as much as on the actual merits of the child's work. In some school systems it is not permissible for a child to spend more than two terms in a grade; after that he is promoted regardless of achievement. This depends partly on whether the local schools are equipped with special classes to care for those who cannot progress at normal speed. For the other end of the curve of distribution, policies differ as to extra promotions, rapid-advance classes, or so-called Terman classes for supernormals; skipping is taboo in some places, but is the only solution in some other less richly endowed locality. Rapid advancement through skipping often has disastrous results; in terms of grade placement a certain amount of retardation for mental age is a salutary measure for the most highly supernormal children. Full advancement in strict accordance with the individual's mental age, with no regard for his physical, physiological, or emotional development, can be and usually is a dangerous policy. It is axiomatic that as our growth within any one sphere is irregular, so are the growths of the several spheres imperfectly correlated. The child of

nine with a mental age of sixteen, seemingly capable of competing in the intellectual field with second-year high-school pupils, runs amuck if actually placed in that situation. He is not capable of meeting the comparative freedom of a high-school régime, which offers countless signs of emancipation eagerly heralded by the adolescent, but opens a darkly ominous wilderness to your pre-pubescent youngster. This is true of both the academic and the social life in high school. The child is, first of all, used to short, definite, fairly rote assignments, and is introduced quite suddenly to new ways of studying—small research jobs, the seeking of causal relationships and principles of growth; no longer does it suffice to know the date of William the Conqueror or the chief exports of Russia. Not only must he read quite widely, but often must select his own bibliography. This is neither impossible nor unpleasant to supernormal children, but as accelerated young pupils, they need much more guidance than they are given in the ordinary high-school setting.

What would the reaction of a nine-year-old be to a high-school dance when normally at that age his contact with girls simply means including them in the least rough-and-tumble of his outdoor games? What place would you give this nine-year-old on the football team? What chance would he have in any athletic contest? What attitude would he build up in defense of his perfectly normal temporary physical inferiority?

We expect, then, that whenever an educational plan is mapped out for a supernormal child, it will be with due consideration for his all-round development and a recognition of the serious dangers inherent in too rapid advancement.

Having disposed in general terms of the responsibility of educational policies toward the supernormal child, it is desirable to consider the more personal human relationship of the teacher-pupil situation. There is, first of all, the indubitable fact that the teacher's attitude toward her pupils and theirs toward her influence the report-card marks. As long as the two principals in the situation are interacting personalities, the error of prejudice will persist. It can be lessened in importance, no doubt, by the growth of objectivity, a growth dependent not only on the increased use of stand-

ardized-test material and refined rating scales, but more largely on the development of personalities. Just as emotional maturity, detachment, objectivity—call it what you will—is being set as the goal for those in social service as a prime factor in successful treatment, so must it be held an equally important goal for teachers, who more than any other adults except parents come in contact with the school child.

Personal bias not only affects report cards and promotion lists, but, more significantly, behavior reactions in the classroom. There is not time to digress into the teachers' own problems as they affect the solution of the child's difficulties—how, for example, some respond to attention-seeking while others thwart it, either punishing the child for their own early deprivations or identifying themselves with the child in order to satisfy their needs through him. There are some, of course, who do meet their pupils' problems with the wise, mature handling we should always like to see, discreetly combining their warm personal interest with attempts to develop in the child a healthy independence, something quite different from an undesirable protest against reasonable authority. We do not for a moment overlook the fact that personal prejudices in the classroom can result in indulgence as well as deprivation, and in either case we are combating an unhealthy situation. Reaction to the charming graces of a certain supernormal youngster worked in one case to provide a perfect substitute for the security experienced at home, particularly as the desire for it was deep-seated in the boy, who had no impulse to free himself and was satisfied with failing marks because of the complete libidinal satisfaction gained by the attention and indulgence of his teachers.

What other mechanisms do we discover utilized in school by the immature supernormal child to solve his emotional problems? The case just mentioned is an example quite perfect in all its details of a satisfactory libidinal experience within the school walls. Should the desire thus to extend the protective home situation be thwarted, innumerable other combinations of behavior reactions may result. Perhaps the child, a rival with classmates in school as he is with sibs at home, is jealous of the teacher's attention to any but himself. He may then draw a negative satisfaction from sulking or

neglecting his home work, because that will attract her attention, or he may exhibit more aggressive behavior, studying purposefully to gain approval. The aggressive reactions are not always as desirable even as this on the surface, since the child most frequently solves his problem by annoying both teacher and classmates, with humiliating success. In such a case tantrums, teasing, disobedience, impertinence, and all other irritating conduct place the pupil in the center of the stage, but are too often accompanied by school failure. The attention gained from being singled out of the group gives more satisfaction than a peaceful existence as only one among thirty other boys, characterized in an undifferentiated category as good students. There are many other ways in which a child may compensate for lack of attention from the adults in school. He may boss and bully, or he may protect other children. He may withdraw his energy from academic work and throw it into athletics, gaining his satisfactions from physical competition with his fellows, thereby punishing the bad parent of the schoolroom by ignoring her.

Suppose home offers little or no satisfaction. Perhaps the child will then try to find his security in the school setting with some such results as have already been described. In the event, however, of the identification of an unpleasant home situation with the school, in which the stern parent is reflected in the teacher or the entire question of obedience to authority at home is made one with the compulsion to attend school, behavior may again take the form of aggressive or withdrawing compensatory or protective devices. Whether behavior is such that the child obtains revenge by overt misbehavior or takes refuge in phantasy, excessive reading, and the like, it leads in either case to relatively poor or positively failing work. If mother or father insists on college for Johnny, who wants to elect a commercial course, the immediate reaction will be in accordance with his affective development. Either he revolts, if he is struggling toward emancipation, and successfully solves his problem, or—the more usual occurrence in elementary school—he remains in conflict, unable to attack his work with proper effort or interest, failing thereby to satisfy either his parents or himself. The third possibility is a regressive reaction in which he pleases his par-

ents, remains secure and infantile, but derives no maturer ego satisfaction than before.

This matter of projected parental ambitions presents one of the most serious among educational problems. It is so natural —and so harmful—for parents whose own desires for success have been thwarted to try to compensate through their children. Some of the most difficult cases have developed from this basal factor. It seems hardest for parents to realize in a more than superficial intellectual way that they are traveling the shortest road to another thwarting. The hope lies with these supernormal children, in giving them insight into both the parents' problem and their own mechanisms. Many of them are tremendously keen to grasp the import of the situation and are able to meet it, with the help of a psychiatrist and social worker, with a socially desirable adjustment.

Sometimes the parental projection is associated with only one school subject, but occasionally it extends with an enormous overemphasis over all intellectual undertakings. Then, in a desire to please, we have the academically successful, but perhaps socially unsuccessful child; or, again, a healthy protest and reversal to extra-academic activities, with a pretended contempt for scholastic achievement, though any supernormal youngster would, without the emotional blocking, derive satisfaction from his intellectual equipment.

There are times when the child, as a protective measure, himself overemphasizes the intellectual, a reaction often accompanied by withdrawal from social contacts because of a feeling of inadequacy and insecurity. The youngster who reads, reads, reads, is protecting himself from inability to meet his fellows on common ground, perhaps because of his own physical inferiority, if he is a supernormal child unwisely accelerated or physically underdeveloped. Sometimes, in a kindly, but misguided desire to offer him intellectual stimulation, a gifted child is placed in a school attended by children who will not accept him socially. Then his inability to cope with the social situation in school results in unhappiness and classroom failure, as his efforts to protect himself or compensate for his deprivations require a disproportionate amount of time and energy. There are many kinds of competition which

these children enter upon in a miserable effort to gain substitute satisfactions.

Perhaps one of the most deplorable conditions is the formation of bluffing, careless habits, among these children who can "get away", as they say, with half an hour's preparation instead of two, and who frequently get their lessons only from hearing the class recitations. Two high-school girls whom I remember particularly spoke spontaneously of a lack of incentive, and gave it as their opinion that they had bluffed all through and never achieved the marks they could have. It is of considerable importance that both these girls were using their intelligence as a weapon of defense, wielding the "big stick" on an extremely infantile level—neither with any feeling of responsibility nor with a developing sense of what achievement might mean to them on a higher ego plane. One of these girls has had to repeat her senior year at high school; the other, with just passing marks, played truant continually before her admission to the bureau.

From the long list of possible reactions—and it is by no means complete—only one general statement can be made: In an educational problem, as in every other case of human behavior, the individual chooses what gives him the most satisfaction, solving his difficulties in whatever way he can. Some withdraw, and some are aggressive, some protect themselves and others compensate, according to their inner needs and the force of external circumstances.

Whatever the manifest or latent reactions, we find again and again the supernormal child not living up to his potentialities. Sometimes the retarding influence is so strong that the child is not recognized as superior or is even classified by the unsuspecting teacher as dull, until, as part of the all-round clinical study, the testing procedure brings to light his supernormality. Even then the trained examiner realizes the unreliability of such test scores and, upon retesting after a period of psychiatric treatment, a still higher degree of superior intelligence is reached than on first testing. Take an instance in which the child showed comparative failure in both native intelligence tests and school achievement. This child, a girl, ten years and two months of age when first seen, presented an unusually distressing social background. For the first four

years of her life she was neglected, frightened, and abused by a mother who was in her turn driven by a tremendous emotional conflict. The active abuse was later displaced for a time by a period of indifference on the part of the mother, until finally she became desirous of making a better adjustment and came to us for help. At this time, the child was finding extreme difficulty in adapting to the presence of a younger brother and sister, who emphasized, unconsciously enough, her isolation from the mother. Upon coming to the clinic, she was found to be extremely upset and, in addition, unfit for fifth-grade work, her normal placement, though she obtained at that time an intelligence quotient of 115. Three years earlier at another clinic, when the problem had been not nearly so acute, examination had revealed an intelligence quotient of 128.

Study of her school record gives a history of inability to concentrate as early as her first school year. In addition to this manifestation of an emotional problem, when she came to the bureau, Edith felt unwanted, thought she was no good, complained of unfair treatment, was jealous of her younger brother and unable to make friends, attempted to dominate by being bossy and demanding her own way, and ambivalently showed an overwhelming desire for friends and affection. She was growing seclusive, sat dreaming and sucking her thumb, was afraid of the dark, and had been stealing and then lying in self-defense. She was failing school as a result of her inner conflict and inability to attend to anything but her emotional life, and of course was suffering great distress because of her younger brother's school success. Treatment was indicated and carried out for the mother before any change could be made in the child's reactions. Treatment for Edith herself consisted mainly in giving her insight into her feeling toward her brother and sister and her attitude toward school, as in neither the home nor the school setting did she feel any security. At home she was keenly aware of her mother's partiality and favoritism; in school she felt her teacher to be unfairly critical. The child admitted that as a result she was not trying to study. When threatened with demotion to her brother's class at one time during treatment, the child's distress was acute, her unhealthy reaction being that if she were left back,

she'd never study again. The insulting experience was avoided by a brief period of tutoring to which Edith responded very successfully. When, after several months of treatment, she had to be transferred to a new school, she had reached the point where she could say: "I begin to understand that I am the biggest and can copy from my mother and father. . . . When I get to that new school, I know that I am going to make friends all right. When I don't have just as good things, I won't mind." After the school transfer, she remarked to the psychiatrist, when questioned as to her daydreams, "I used to do it in that other school because I was so unhappy, but now everything is so much better I don't have to." A month later she had an excellent report card and was promoted at the end of the term. That brings us, at the end of ten months of treatment, to the date of the retesting, which gave the following result: The Terman score obtained was an intelligence quotient of 136, a rise of twenty-one points over the previous testing. Now just eleven years old, she was in high fifth grade, approximately normal placement for her chronological age, but of course considerably retarded for her mental age of 14 years, 11 months. She made an improvement of two school grades on a standardized arithmetic test, now scoring fifth instead of third grade. She obtained an eighth-grade, against a previous record of a fifth-grade, score in reading, though she did not improve on her previous fourth-to-fifth-grade score in spelling. It is obvious that the school situation cleared up with the better adjustment at home. As she felt assured of a place in her family group, assumed the responsibilities of the oldest child, and ignored opportunities to fight with the brother who was her nearest rival, the need to find satisfaction in daydreams at school and to identify her teacher with a bad mother at home dropped out of the picture. The present finds Edith in a rapid-advance class where she belongs.

The following is the case of a boy twelve years and one month old, an attractive, accommodating, winning youngster with an intelligence quotient of 130, who is referred as an educational problem. He is in junior high school and is failing in all five subjects. He is described as irresponsible, lazy, indifferent, and slow. One teacher, either by happy accident or true insight, hit the keynote of the problem, remarking to the

worker that the boy required "the supervision the departmental system at ——— School cannot give". How true that is in its deepest psychological sense we realize after making a careful analysis of the boy's emotional life. By the death of his father, he was left a half orphan at the age of six months, and we see the mother transferring in intensified form all her libidinal as well as many of her ego desires to the boy for satisfaction. By waiting on him hand and foot, she deprives him of any opportunity to assume responsibility or to feel grown-up, yet she plans an elaborate academic career with a professional goal, a matter in which he is naturally taking no interest. In addition, after an eight years' absence from the home, two older sisters returned, while the older brother married and dropped out of the picture. He does not serve in any way to draw the mother's attention from the youngest child, but, by marrying against the mother's wishes, has thrown her all the more intensely on to the other son. At the time of study, this very bright youngster appears as the avowed center of the home, the pet of three adoring womenfolk, who believe in his good ability, but foster every opportunity to fulfill their own emotional needs by keeping him a baby. Unfortunately, this boy, unlike some others, is completely satisfied by the security of his infantile attachment and makes no attempts to free himself. He basks in the affection of his teachers, who are sometimes admittedly and sometimes unconsciously won over by his charming personality to forgive his irresponsibilities, thereby fostering his mother-son dependency. In consequence, the boy, entirely to his own satisfaction, has constructed a school experience approximating the comfortable infantile situation at home. It becomes unnecessary for him to derive a more mature ego satisfaction from success in the intellectual field. The attention that his school failures bring him is again a destructive, but a very satisfying experience. Nothing will make this lad react healthily to academic activities but treatment based on a recognition by the school, his family, and himself, of his immature emotional development.

As early as first grade he played truant, avoiding what he felt irksome responsibilities in order to enjoy a friendly reception at the fire-engine house. For the first six years of his school life things went fairly smoothly, however, and twice he

made two terms in one. Because of his good work in sixth grade, and his high scores in group tests of native intelligence, he was transferred to a junior high school in the rapid-advance seventh-grade class. The comparatively free atmosphere of the new setting proved too difficult for Harry. His marks fell from his customary A's and B+'s to C; he left his lessons at home or didn't do them at all; he became tardy and generally undependable when left to his own devices, and slowed up in all his activities. A visitor from another agency gave him intensive supervision for a year, in such a way, however, that his dependency was increased. Instead of helping him to assume his own obligations, she called at home for the work he forgot to bring to school; she helped him to get assignments from classmates when he forgot his own, and obtained the services of a volunteer to give him French lessons. In fact, she securely walled him in, and then at the end of a year, noticing improvement, she dropped the case from her active list. What happened immediately was a far worse slump than before, bringing Harry to the bureau as a serious problem.

Take an unusually clear case of identification with, this time, a "bad mother" instead of an entirely satisfying one, in which the child, a girl of fourteen in third term of senior high school, is reported to be failing in Latin and slumping generally in all her marks. Her Latin teacher reported: "She is an average student, nothing exceptional. She is serious, earnest, a hard worker, probably doing about the best she can. In class, though she is attentive, she is passive, not alert, probably because her response is slow, not that she is dull. As she develops, I believe she will improve as a student, but will never be brilliant." This seemed to throw light on the problem until examination revealed an intelligence quotient of 120. Evidently, then, Sarah was not doing the best she could. The next step was to inquire into the social relationships of this girl in an effort to find the factors underlying the school failure, which was only one of the symptoms for which she was referred to the clinic.

Among the essential facts for this aspect of her problem we find the presence of a mother of considerable intelligence whose life has been a series of thwarted ambitions in the edu-

cational field. Her desire had been to enter upon a professional career, and with that still in mind, she attends college evening courses while the girl views her efforts with contempt. The mother, we find, has continually nagged this daughter about her school work, urging her to prepare for college and supervising her methods of study with exasperating attention to detail, while the girl ardently desires to make music her main study, but is unable to dominate the situation. What happened is of tremendous interest to the psychiatrist. The mother has always been a splendid Latin scholar, and we find this capable girl failing in that very subject, identifying it with her mother, who is thwarting the child's natural desires and who, as an added insult, lavishes her affection only upon the younger sister. We find further identification in the girl's spontaneous expression of dislike for the history teacher. The connection here lies in the fact that the mother, worried over her daughter's failing marks, had a particularly long conversation with Sarah's history teacher. As the girl herself put it, "I feel so uneasy when she [the history teacher] is around. She and my mother had a talk about me and now she knows what my mother thinks and I guess she thinks the same." In other words, the history teacher now also becomes the mother, whose attitude toward her, the child feels, is unsympathetic and unfair. Sarah was quite sure she could make good marks in history if she had another teacher. Instead of allowing such a change, the psychiatrist, of course, took up the matter of identifications as a mental-hygiene issue; a couple of weeks later Sarah's mark in a history test was 86 and her opinion was changed to read, "I don't know but what I like that teacher some after all." Furthermore, the patient gives full vent to her feelings about bright people in general, a protective device against all who, like her clever, though non-understanding mother, may cause her discomfort and insecurity.

Instances of projected ambitions are among the most distressing because of the severe double problem involved. Parents not themselves in conflict have no need so to overemphasize educational opportunities and academic goals that their children turn from the desired ends. It is precisely the parents who are so driven by their own needs who force their children into an expression of independence which ends in the

parents' defeat. The problem is, then, twofold: to give the parents sufficient insight so that they are able to withdraw the pressure and allow the child some freedom of choice, and to give the child an understanding of his own behavior symptoms—the undesirable ways in which he has been punishing his parents in an effort to emancipate himself, but which have operated to deprive him of healthy satisfactions.

Those problems of school failure which hinge on emotional situations of one sort and another will not be solved by careful analytical testing, nor the best of tutoring, but can be handled efficiently only from the same point of view from which one treats any symptomatic behavior—an intensive, painstaking study of the personal relationships, social situations, and psychological mechanisms involved in the patient's manifestations of his maladjustment.

THE THERAPEUTIC APPLICATION OF PSYCHOANALYSIS

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WHEN Freud was invited by Clark University at Worcester, Massachusetts, some fifteen years ago, to speak of psychoanalysis for the first time to an American audience, his presentation of the subject was essentially from the therapeutic standpoint. This was not only historically logical—it was also natural from a personal point of view, since Freud himself had started as a neurologist. But he was dissatisfied with the neurology of that time, and so had turned his scientific ambition into this new field. In spite of the tremendous progress since made, by psychoanalytic investigation, beyond therapeutics, Freud has really never quite given up his original medical point of view, and has tolerated the penetration of psychoanalysis into wider circles of cultured people with a certain uneasiness. This attitude indeed has some justification, especially when such popularizing of psychoanalysis is possible only in a rough, crude way and by means of striking catchwords. On the other hand, the fierce resistance that Freud's doctrines aroused in his colleagues seemed to indicate that the destined way of psychoanalysis would be through its appeal to the public.

So if I am to speak of psychoanalytic therapy as the original practical side of psychoanalysis, I must announce beforehand that, in view of its present-day position, it would be more correctly spoken of as the application of psychoanalysis to the therapy of neuroses. For in the last decade the psychoanalytic doctrine and movement have extended far beyond the bounds of therapeutic interest. Formerly the question was, How can medical analysis be applied to other sciences or to practical life? To-day, the task is more and more to single out, from the vast psychoanalytic system, those results which can most profitably be used in therapy. Naturally I do not mean by this to place a final limit to what the psychoanalyst should know

of psychoanalysis; but rather to establish a permanent mutual relationship between analytic investigation and the practical application of its results to therapy.

In addition to this development within the science itself, which, with the advance in our psychological knowledge, naturally increases our therapeutic abilities, we must also bear in mind the increase in the popular knowledge of psychoanalysis and the greater willingness on the part of the public to accept its point of view. This may be called a kind of mass therapy, an analytic enlightenment of society in general. Naturally this cannot have as deep an influence as a methodical individual analysis, yet on that account it has a wider influence. We have already discussed the general social importance of this fact and shall have something to say about its cultural importance later.[1] Here the question is, What influence has the penetration of psychoanalytic knowledge to the public had on the therapeutic side of psychoanalysis? The fact that psychoanalytic literature is eagerly read by the public, that its problems are discussed extensively in literature and even in the daily press—this fact would be nothing in itself if psychoanalysis as a therapeutic method did not occupy a unique position in medicine. To be sure, other medical problems important for humanity, such as the investigation of cancer or the question of tuberculosis, are publicly discussed. But psychoanalysis has two characteristics that make its position unique: First, the general human importance of it keeps the interest of the laity focused on its contents; second, the knowledge of the psychoanalytic discoveries itself constitutes a part of the therapy, and so far, apparently, the doctor has no advantage over the patient.

This fact must not be neglected, but, on the other hand, its influence must not be overestimated. Breuer made the discovery that neurotic symptoms disappear as soon as the patient remembers the repressed experiences that cause them. As long as the patient himself had to search for these in his own unconscious, he necessarily had to live again these experiences affectively and abreact them in that way. Then Freud

[1] See *The Significance of Psychoanalysis for Social Life*, by Otto Rank. MENTAL HYGIENE, Vol. 10, pp. 253–64, April, 1926. The cultural importance of psychoanalysis is discussed in an article to be published in the October number of MENTAL HYGIENE.

later discovered that these experiences, which differ with the individual, had a traumatic influence because they reawakened earlier typical experiences which had been inadequately overcome. Through knowledge of these typical experiences, one could save the patient the trouble of looking for the original traumata; but one had to replace in some other way the reproduction of the affect, which is essential for the therapeutic result.

This occurs in a way that is quite independent of the knowledge of the repressed experiences, because this part of therapy is *not* of an intellectual, but of an *emotional* nature. In this direction also Freud went far beyond Breuer's katharsis. Breuer, as you will remember, fled from his work on neuroses when his patient announced to him, and at the same time acted, the delivery of the child allegedly begotten by him.[1] Freud obviously was able to free himself to a greater degree from human vanity and so to judge the problem objectively. He soon noticed that other patients adopted the same emotional attitude toward him that would be described in ordinary life as "being in love". But *he* was able to say to himself that this was not on account of any special attraction of his personality, but lay in the nature of the patients themselves, or in their suffering—belonged, so to speak, to the utterances of the neurosis. In this way he made the real psychoanalytic discovery, which he called transference—that is, the fact that human beings in general have a tendency to attach their libido (to a certain extent always free-floating) to a given object. In doing this they gain great satisfaction, which is sufficient to serve as a substitute for the *unconscious gain of illness* that the patient previously got from his suffering. In analysis, in the patiently continued daily occupation with the patient's most intimate unconscious feelings, the conditions for such a libido transference are especially favorable. One comes thus into a position to grasp, as it were, the whole libido in its purely concentrated form. The psychical analysis of this libido transference which was necessary for the healing and freeing of the patient gave a remarkable result, the practical importance of which went far beyond the thera-

[1] *Psychoanalysis as General Psychology*, by Otto Rank. MENTAL HYGIENE, Vol. 10, January, 1926. P. 15.

peutic field of the analysis of neuroses and made intelligible a large part of normal psychology. It showed, namely, that the patient's attitude, which one could mistake for love, had throughout nothing new in it, but was to be explained historically as an exact reproduction of the earlier relations of the child to the parents. It also showed that the patient, not only in the analysis, but also in life, was constantly compelled to reëstablish and to repeat this attitude. Thus the analysis of the transference led to the discovery of the infantile Œdipus complex in mankind. It was so-called because the Greek hero, in unconsciously killing his father and marrying his mother, represented the most extreme realization of this libidinal parental relationship.

I should need a good deal of time to show you the importance for the development of the individual, as well as of society, of the Œdipus complex, which has become the kernel of psychoanalysis. But let me tell you only the most important results. The relation of the child to the father and mother determines in conclusive ways the love life of the human being, as well as his social behavior. Not only are the love objects of both sexes chosen according to the model of the first infantile love object, but also the child's ideal formation, so important for the general social attitude, comes originally from the parents. These are later replaced by other persons somehow substituting for them, as, for example, teachers, public officials, heroes, and so forth. An exact study of the development of the Œdipus complex in the child, which the analytic transference situation allowed us, has made necessary a somewhat complicated formulation of the facts with reference especially to the difference of the sexes. As analysis was almost exclusively practiced by men and the theoretical work of the analytic results was elaborated by men, it was at first easy to assume that the transference libido in women as well as in men patients contained the infantile relation to the father. This was, namely, in the case of the woman the heterosexual component, in the case of the man, the homosexual. Naturally one could not be satisfied with this in the analysis. But often enough the chief task consisted in having to free from repression just the other libido component not manifest in the transference. Thereby, from the purely

psychological side, a discovery was made that corresponded to the biological fact of the original bisexual disposition of mankind. This was, namely, that the man was capable of a feminine libido attitude in the unconscious, leading up to phantasies of pregnancy and birth; and that the woman in her unconscious often had a masculine libido attitude, which expressed itself in the extreme form as a phantasy of possessing a man's genitals.

Whereas Dr. Breuer was afraid that his patient was personally in love with him, and had formed the delusion of having a child by him, Freud was able to explain from his observations that this was no isolated case and nothing special. Every patient is in love in a certain sense with his doctor, the difference from real love lying in the fact that this emotional attitude in the transference is quite independent of the personal qualities of the doctor. Thus it rests on a general law, which is intelligible from the development of the human libido in the Œdipus complex. It was observed, also, that the actual sex of the analyst, in comparison with that of the patient, formed no hindrance to the elementary libido striving. For example, the man analyst can represent for the unconscious the mother as libido object, besides, as we already know, personifying the father. From this observation the difference between "being in love" and the transference was made still clearer. Accordingly a deeper analytic work gave a quite specific formulation for the transference libido which went beyond the sexual conception of the Œdipus complex. The deepest unconscious of the human being knows, namely, only one original libido binding, which is not only the first, but also the most intensively experienced, and that is the libidinal connection resting on the biological relation to the mother.

It may appear to you curious that so obvious and simple a fact—that all love finally rests on love for the mother—had to be discovered by the complicated method of the analytic situation. If I attempt to show you the reason for this, you must not consider it an irrelevant deviation from our theme. It will, on the contrary, introduce us to the real problems of the psychical life and their solving. I do not know if all great discoveries finally concern some simple fact, which had been previously overlooked, as one used to say, for some other

cause. But it is certain that all the essential discoveries of psychoanalysis concern very simple things, and that only the way to their revelation was complicated. For example, that the dream is a wish fulfillment is expressed in numerous folk beliefs, proverbs, and poems; that small blunders of everyday life could have a meaning was also, before analysis, incidentally known, especially in relation to love affairs. The same psychology relates to the blunders as to quite a number of widespread superstitions. Symbolism also was not only familiar to the ancients, but is understood by our contemporaries in wit and in folk songs, as for example, in your American song, *"Yes, I Have No Bananas"*. And the fact of infantile sexuality, discovered by analysis, is so obvious that one not only wonders that a discovery was necessary, but one is astonished at the violent resistance encountered by this as by all other analytic perceptions. People's resistances to the conscious acceptance of scientific facts that one likes only tacitly to recognize betray, as analysis has taught us, the activity of the repression tendency. This repression tendency cannot deny the reality of certain things, but it attempts to prevent acceptance and recognition of them.

Naturally, here there are again at work strong affective factors, in no way intellectual, which cause and maintain this tendency to repression. The libidinal relation between mother and child has not only been consciously recognized at all times, but has been sung with the highest praise as mother-child love. It is, therefore, rather difficult to see what repression tendency should have prevented us from recognizing this immediately in the analysis as the deepest root of the phenomenon of the transference. It should have been easy to understand that the original libido aim must in the very deepest sense strive for the mother, who even before the beginning of the individual life satisfies all the child's needs, those of protection and nourishment especially. But from the study of neuroses I could show that for the unconscious this prenatal libido situation is just the ideal prototype of every later libido satisfaction in life. It contains what we might describe as the general desire for blessedness. Only, as a complete satisfaction of that kind can never later be obtained, this fact gives to the libido the character of insatiability, and gives it also its capa-

bility for expansion, displacement, transference, and sublimation. These characteristics lead to the most primitive acts of adjustment as well as to the highest creations of culture. Of the greatest importance, and in its psychological consequences still not at all appreciated, is the moment of birth, in which the living being is deprived of this blessed primal gratification, and so has to put up with various kinds of substitute satisfactions. Through this fact of the loss of an irreplaceable source of pleasure, birth becomes a severe trauma. This trauma of birth establishes on the one hand the primal repression which has to do with the irretrievable paradise; and on the other hand compels a forward striving which exhausts itself in constantly repeated attempts to gain substitute satisfactions.

I have attempted in a psychological work[1] to outline in a general way the effects of the birth trauma, and I would like here to refer shortly to its importance for psychoanalysis, especially for the doctrine of neurosis. The central problem of the neuroses is anxiety, whose solving occurs simultaneously with the freeing of the unconscious mother fixation. In every individual the primary factor is anxiety as it was originally experienced by the child at birth in the physiological apnœa and then became psychically anchored to prevent regression. This primal anxiety must always be reproduced as often as the libido in its regressive tendency approaches this border whose overstepping would signify a renunciation of reality, such as occurs in the psychoses or in suicide. So we recognize in anxiety a biological guard against the libido's regression to the primal state, which state would be equivalent to death. According to the level in the individual at which this anxiety is fixed, it reacts in a definite type of character, as also (when it falls into neurosis) in the formation of symptoms. These symptoms I have been able to trace back as being reproductions of the birth trauma or of the intra-uterine condition.

I regret that I cannot here illustrate these assertions, which may seem to you bold, with examples from neuroses. I must be content with assuring you that from this discovery, which

[1] *Das Trauma der Geburt und seine Bedeutung für Psychoanalyse,* by Otto Rank. Leipzig: Internationaler Psychoanalytischer Verlag, 1924.

is based on numerous experiences, not only a practical, useful doctrine of types could be developed, but also a definite psychoanalytic symptomatology. This would supplement the clinical symptomatology from the unconscious side. Thus one is able to recognize from the symptoms that traumatic primal form to which the ego of the patient has regressed, and is in a position to solve therapeutically the libidinal mother fixation. This is accomplished by rousing the anxiety and freeing it in the abreactions on the specific border of repression. Thus the knowledge of the patient's typical reactions according to the compulsion of repetition served as a means of help. We know from experience that the patient's peculiarity is clearly displayed at the beginning of the analysis. So, too, the analyst by his training is in a position to recognize at the very beginning the form adopted by the patient when he failed to master his primal trauma.

You must not immediately feel that this new point of view, which I introduced into analysis, is an unexpected and undesirable complication of the psychoanalytic theory. Consider it rather, although it leads into the deepest biological layer of the unconscious, as representing an essential simplification of the psychoanalytic results. It is in its nature, as in its possibility of application, a purely practical result. This discovery, like every advance in science, makes some of the earlier theoretical assumptions practically superfluous, but does not on that account diminish their scientific importance. There is no contradiction in the statement that psychoanalytic investigation has become ever more complicated in its work of interpreting and formulating theories and ever more simple in its scientific results and practical applications. And at a certain point of knowledge, the way in which that knowledge was discovered does not matter; only the practical use of the knowledge is important. Therefore, I need not explain to you here in detail the difficult and complicated process by which the fact of the birth trauma was found; nor need I show you how its importance for the development of the whole human race was recognized. Our entire psychoanalytic knowledge, including the complicated technique of interpretation, had to be placed at the service of this investigation, which we now can use for its practical application.

In regard to this experience also, it would not be enough to make a simple statement of facts to the patient, as it would have been in Breuer's experiment. Since the tendency to mother regression is the essence of the libido, we ought not to expect to alter this biological force by merely explaining it. For the cure itself we need, in addition to this, another analytic point of view, which is derived from the dynamic psychology of the ego, to which also belong the therapeutic processes of consciousness and becoming conscious. The freeing of the libidinal mother fixation is only the first therapeutic step in the analysis, which corresponds to the original physiological separation of the child from the mother—namely, birth. The second part of the analytic work consists chiefly in what Freud has called reëducation, which is similar to the education of the child after birth and is mainly an ego formation. As the educator—or the parental authorities whom he represents—makes possible to the child an ego formation in the way mentioned in a previous paper,[1] so the analyst has to strengthen or weaken the undeveloped or overdeveloped ego of the patient—that is, to bring about the appropriate changes in his attitude to the biologically given unconscious and subsequently to reality. Just as the child does this only out of love for his teacher, so the process of reëducation of the ego during the analysis is carried through by means of the transference. This transference, after the freeing of the mother fixation, must be transformed into an identification with the analyst, as an adjusted representative of the outside world. Finally this identification has to be analyzed and transformed by the sublimation process of the healing into a new ideal or super-ego created in the patient himself.

For that purpose the analyst also has to deny himself many things, even as he demands and must demand certain renunciations on the part of the patient. He must be able to give up from the first any scientific ambition that may lead him to wish to discover something new from his patient's unconscious. He must be prepared with this knowledge. He must further be so sure of his knowledge and its application that

[1] *Psychoanalysis as General Psychology.* See note 1, page 497.

he can resist the temptation to prove to his patient this and that, to show why the presuppositions of his theory are right. Of course the patient must grant that degree of authority which he would allow without further ado to any other specialist. And he must accept with a certain amount of confidence any explanation from the analyst. This need not necessarily be an interpretation, but a communication, and it must be accepted as an explanation would be from any other medical specialist. Lastly, the analyst, on the strength of his deepest knowledge, must give up all idea of changing the patient's biologically given unconscious, which finally represents the embryonal and the phylogenetic surviving in us all. The analyst can bring the patient only to recognize the unconscious, and to correct his conscious attitude toward it in the sense of a reëducation. Thus the analyst will be in a position, not only to obtain therapeutic results in a shorter time, but also, with less therapeutic ambition, to bring about in the personality of the patient many intense and lasting changes which will protect him from further regressions and fixations.

This second part—the analytic education, which really lengthens the cure—must bring about, simultaneously with the new ideal formation, the freeing of the transference relation to the analyst. The patient has been compelled by the transference to loosen this regressive mother fixation bound up in the symptoms, so that the libido is now available in the analysis, and can be forced into a progressive direction to form the new ideal and to achieve readjustment. The first part of the task—namely, to get the transference of the libido to the analyst—is easy; the danger lies in the possibility of the patient's libido remaining fixed in the analysis as it was formerly in the symptoms. Whether the patient is really in love with the analyst, as is more easily possible with women patients, or whether, as is more the case with men, there is merely an intellectual and social dependency, the effect is the same—namely, a failure. In a correct analysis, both must be unconditionally avoided, unless one wants to get into the position from which Breuer in his time found no way out. Whether the analysis has really accomplished anything for the patient will be shown in the freeing of the transference—that is, if the patient does not again repeat and maintain the

symptoms that disappeared during the course of the analysis. Psychoanalytic therapy does not by any means aim at the mere putting on one side of the symptoms, which can be attained by other and different methods; it aims at preventing the possibility of their return. And for this the knowledge of their origin does not suffice. Results that disappear as soon as the analyst attempts to free the patient's libidinal fixation on him are due only to the success of the transference, as in Breuer's case. Real psychoanalysis, on the other hand, is a radical therapy, which starts out by removing the conditions to which the symptoms owe their origin. This is not possible by merely communicating analytic knowledge to the patient. An emotional reëxperience is necessary. This reëxperiencing becomes finally a form of application which the analyst on the strength of his own knowledge and power uses for the patient's benefit. If I were to illustrate this by a drastic example, I would say that the analyst acts in the cure as is reported of a doctor in the South, who is said to have announced: "If I don't know what's the matter with a patient, I throw him into a fit, and I'm hell on fits." Thus the analyst can bring about a radical cure only by first rousing the repressed conflicts before setting to work to solve them.

As you will note, a certain amount of active intervention is necessary, but this is not specially characteristic of psychoanalysis, but belongs to every therapy. If you will not misunderstand me, I would like to illustrate also the active-affective character of our present-day psychoanalytic technique by an example with which you all must certainly be familiar. Long before analysis, literature made use of this motive, and it has again recently become fashionable in connection with psychoanalysis in the theater and even in the movies. In general the plot is that the hero completely loses his memory, owing to some severe psychic shock; or, as we would put it, a total repression of the content of consciousness takes place in him. The author usually arranges that he shall get his memory back again, and at the same time be restored to complete psychic health, by being exposed to another shock of the same kind, where possible in the same situation. This also I believe is a common occurrence of everyday life: I think of something I want, which is in another room; I go to fetch

it; and when I come to the room, I have forgotten what it was I wanted. I retrace my steps and turn again to go to the other room to exactly the same place at which I was conscious of the desired object. Immediately the memory returns, and this time I succeed in fetching the object. In the same way, only with much finer psychical means and with no help from the outside, we expose the patient in analysis to his primal trauma, and allow him to live through the experience again. May I add that this conception—namely, that of curing illness by means of the same germ or shock that caused the suffering—is indeed an ancient one in medicine, and even our modern serology rests on the same principle. As psychoanalysis has recognized that the neurotic is, finally, one who suffers from traumata which most people successfully overcome, so our therapeutic method consists in the reëstablishment and reproduction of the libidinal mother fixation in reference to the analyst, and in the surgical cutting of this psychical umbilical cord, with which the patient has hitherto always been burdened. When this once has happened, the libido, previously fixed at an infantile level, is transferred almost of its own accord to reality by the process of the new ego formation. The whole process corresponds biologically to the bodily separation from the mother and the identification with the father, and socially to the task of education, which has to make the child self-reliant and independent of both parents. Therefore, analysis, straight from the beginning, aims to accustom the patient to independence and self-reliance, in the same way as the pedagogue educates the child. The analyst must at all costs be careful not to spoil the patient in any way; because just the fact of being spoiled—namely, the habit of not being able to give up his desires—has made the patient neurotic. He who wishes to educate or to cure a person only by means of love is like a philanthropist who has undertaken to remove all poverty from the world by an everlasting spending of money. Apart from the fact that economically it would probably be impossible—even though it were undertaken by the richest man in the world—such an event would be harmful, since nobody then would take the trouble to earn for himself. Also we must not forget what analysis itself has taught us—that neurotic people become ill just from an insatiable libido

hunger, which makes them so greedy that the general means of satisfaction—sexual love and socially useful work—do not suffice. They suffer, therefore, as Freud has shown, after all from sexual conflicts, which are reflected simultaneously in the unconscious mother fixation and in the transference relation. With the analysis of the mother fixation, these sexual conflicts can at the same time be solved in the sense that the patient can now reconcile himself, even as do his healthy fellow beings, to the possibilities of gratification offered by normal life. He can overcome his arrest of development in sexual adjustment without entirely giving up the mother libido, for sexual love aims at satisfying and continuing the infantile mother-child relation in a grown-up sense, without ever fully satisfying it in the unconscious sense.

I do not know whether my arguments have made quite clear to you what the real essence of the psychoanalytic therapy is. But you could hardly expect me to present the specific therapy of neurotic diseases in a general lecture as one would in a medical course. Without detailed representation of the forms of disease and the analytic technique itself, one cannot go deeper into the understanding of therapy. I think, however, that such a presentation would rather bore you, and I assume that the general psychological and cultural importance of psychoanalysis has more claim on your interest. Finally, the chief thing is not whether one cures this or that neurotic. The neuroses have proved themselves to be inevitable symptoms of human civilization and culture, and the much more important question is whether psychoanalysis is in a position to show people the ways and means of fighting this culture disease, so that progress may continue without endangering the individual's possibility of happiness.

But the whole development of psychoanalysis, from its beginning to its final conclusions, has shown that everything that we believed we had recognized in the neurotic as a specific disease-forming factor is a general human quality, which has led only in this or that case to a neurosis. We all carry the same complexes in our unconscious psychical life, as we all have the necessary life organs in our body. And we all suffer from the same psychical traumata even as we take in all kinds of bacteria, most of us without being permanently ill or

suffering any evil consequences at all. So the specific in the neurosis is to be formulated only negatively. The neurotic has failed psychically to master the conflicts and necessary adjustments to reality which the normal person has overcome, with a greater or less degree of harm and damage to part of his character and capabilities. Thus psychoanalysis has already gone far beyond the realm of therapy into that of prophylaxis, which is also the ideal of medical science generally, as it is supposed to be the chief task of education to make itself superfluous.

Here, then, in the wide field of prophylaxis, we can make contact with the process of popularizing psychoanalysis, which I characterized in the beginning as a kind of mass therapy. This psychoanalytic enlightenment as to the dangers of the child's sexual development, like the social enlightenment on the subject of the venereal diseases, can accomplish good and lasting results only when applied systematically and authoritatively. To accomplish this we need before everything a generation of trained social workers, educators, mental-hygiene teachers, and doctors who are themselves trained psychoanalytically and who are familiar with the practical results of psychoanalysis. The growing generation of children must be protected from the psychic traumata which psychoanalysis, by laborious investigations of the analyses of neurotic people, has revealed as pathogenic influences. In this way, after the expiration of a time of incubation, everything that we must use to-day in the service of therapy as a means of curing neuroses, by passing into the general knowledge of human beings as parents, will become a psychical hygiene which will play the same part in a new society as physical or social hygiene plays in the society of to-day. We have good grounds for believing that through this analytic work of enlightenment from both sides—therapeutic practice and psychic hygiene—the neuroses in their present form will cease to exist. The sooner psychoanalysis reaches this aim, the sooner will its therapeutic task be terminated, and so much the greater service will be accomplished for the development of mankind.

McDOUGALL'S COMPROMISE WITH PSYCHOANALYSIS

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THE appearance of Dr. McDougall's new book[1] will probably be heralded by psychiatrists and psychologists of all convictions as a work of prime importance. Its importance depends not so much on the intrinsic merits of the book as on the fact that Dr. McDougall wrote it. Holding as he does a most important position in academic psychology and enjoying a justly merited following in England and America, one looks rather expectantly to see where he will throw the momentum of his opinion on the many debated questions in current psychological thought, and where he will look for help toward their resolution. He raises one's hopes high, since it is a well-known fact that he is definitely committed against sensationist and mechanistic schools and has keenly interested himself in the data of psychopathology. He is, moreover, situated fortunately for his task in that he has no loyalties to maintain, no motive to bid for popular favor, and is under no irresistible compulsion to make a place for himself in the sun. In all this the reader's confidence is not misplaced. Dr. McDougall's scientific honesty is well known; he is not disposed, like many lesser souls, to disparage the source of his help, to adorn borrowed concepts with new terminology, and to dispatch their sponsor without sacraments.

The book is at once a comprehensive review of all the modern schools of psychopathology, a criticism of their salient features, an exposition of most of the psychopathological entities, and, finally, a presentation of some original theories concerning their nature and psychogenesis. It is based on a thorough and sympathetic study of the entire literature and on a prolonged experience with war neuroses and other clinical material, an experience that seems to have been limited only by the author's opportunities.

[1] *Outline of Abnormal Psychology*, by William McDougall, Ph.D. New York: Charles Scribners' Sons, 1926. 572 p.

Although Freud is the most frequent target of his criticism, McDougall professes to accept, in the main, the principles and methods initiated by Freud, of whom he says: "I believe that Professor Freud has done more for the advancement of psychology than any student since Aristotle." "I believe in the value of mental exploration as deep as the case requires; and I regard free association and dream analysis as important methods of exploration. But I also hold that exploration in hypnosis is in many cases useful and entirely justifiable. I believe that conflict and repression are principal factors in the genesis of functional disorders; but I believe that emotional shock or trauma also plays a great part in many cases. I believe that sexual difficulties are one of the great sources of disorder and that early sexual strivings and repressions may in some cases prepare the way for later disorder. I am even prepared to admit that sexual striving may occur in infancy in an uncertain number of persons and that, in all probability, such persons are peculiarly liable to neurotic disorder in later life. But I believe that functional disorder may and often does arise independently of the sex instinct. I do not believe that the Œdipus complex is formed in all infants and is the main root of all neuroses, dreams, religion, morals, and civilization in general. Nor do I believe that the symptoms . . . are determined in form by a cunning, designing activity which seeks to render possible a partial expression in disguised form, in order that 'the Unconscious' . . . may enjoy the pleasure or satisfaction of such expressions. . . .

"I believe that academic psychology, even in Germany and America, cannot long continue to resist the inroads of psychopathology upon its preserves; cannot long continue to retain its atomistic and mechanical prejudices. I believe that academic psychology must soon reform and transform itself into a science capable of assimilating all forms of new insight into human nature, and of giving them a due place in one consistent body of knowledge and theory."

For the various rôles of reviewer, teacher, critic, and innovator, Dr. McDougall is rather unevenly equipped. His survey of the various schools of psychopathology is made without any consistency or regard for their respective methodologies; hence he finds himself quite ready, without a flicker of mis-

giving, to adapt the terminologies of one to the other, usually at the expense and to the disadvantage of Freud. His efforts at eclecticism, to get the meat out of each of these various schools, result in a deal of unnecessary confusion and obscurity. He seems to be utterly unaware of the fundamental difference of methodology between a descriptive psychiatry, whose aim stops with explanations, and a dynamic psychiatry, whose purpose it is to reconstruct the methods of nature. His attempts to adapt the concepts and terminologies of Morton Prince and Janet into the main body of Freudian psychology do not, therefore, terminate very fortunately. Moreover, he cannot sift the gold from the dross; to Jung, Adler, and even Stekel he gives a prominence which no sensitive follower of the times can endorse. The worst feature of all this is that he gives a controversial aspect to the book that is quite out of date. It is a well-known fact that Jung-Adler innovations and departures have had their test of time—that for more than a decade and a half the work of neither of these two men has grown, opened up new avenues and problems, or substantiated its validity in application. It is within this very period that Freud has done, indeed, his greatest work and opened up vast territories.

Those parts of the book which are expositions of the clinical entities are woefully inadequate, even from a descriptive point of view. In this regard they are not even elementary, being clogged all along the way with controversial matter and suggested innovations.

As a critic of Professor Freud, the author has proved neither original nor very profound; he uses some, indeed most, of the old war horses of anti-Freudian criticism, though at no time does it become a matter of sticking pins into the effigy of psychoanalysis and burning it in the marketplace, to the strepor of cowbells and catcalls. He preserves a creditable dignity and consistency in his criticisms of Freud in so far as he is able to understand him. The author has a way of calling Freud to account, as it may appear to the general reader, when it is quite obvious that he does not know what Freud means. The weapons he uses against Freud are a monotonous appeal to common sense as a standard by which the truth or falseness of a given observation or conclusion is

to be assessed, the use of dogmatic assertions and denials, and, finally, the constant reference to clinical material which is usually irrelevant or totally inadequate. In this manner Dr. McDougall is constantly confronting the reader with observations drawn from the *war neuroses* to prove that Freud is wrong about *neuroses generally.*

In the original portions of the book, we see Dr. McDougall's limitations more clearly than in any other. He has new ways of making old errors; though he does not at any time confuse physiological with psychological problems, he loses no opportunity to explain matters psychological to the hilt, to the very anatomical basis. He is too easily satisfied with "explanations", and has, of course, no regard for their applicability to clinical problems. It would be rather unreasonable to expect of one whose clinical experience is as limited as his that he should be able—*a priori,* as it were—to evolve a new theory of functional disorders with the merits of originality and applicability. Notwithstanding Dr. McDougall's protestations to the contrary, we regret to state that the new theory of functional disorder is but a very feeble reëdition of that long since proposed by Alfred Adler, with none of the merits of the latter. Dr. McDougall states in fact: "I suggest that Adler's theory might be expressed more clearly, and given a proper place in a complete theory of the neuroses, if he would recognize the two fundamental instinctive tendencies which I have called self-assertion and submission and described as the main roots of the sentiment of self-regard. In Freud's scheme these are used twice over: once as component impulses of the sexual instinct that give rise to all the phenomena placed under the headings *Sadism* and *Masochism,* and again as the active forces of the Ego or Censor. Adler rightly recognizes them as fundamentally distinct from the sex instinct, but makes a confused and exaggerated use of them under the name of the masculine protest or desire for power, and of passivism, or the feminine attitude." In brief, Dr. McDougall's original contribution is his claim to have found a psychology that is based upon a hormic or instinctive principle, and that evades the theoretical impasse of the dualism of ego and sexual instincts. And he does, indeed, devise a formula which he tries to fit upon the descriptive

features of most of the clinical entities, and those that it does not fit—well—never mind.

The determinants of Dr. McDougall's psychological predilections become more obvious when one reads his clinical material carefully and makes some inquiries about his personal contacts with the psychoanalytic method. He tells us in his preface that his personal contacts with functional disorders comprise, almost entirely and exclusively, those occasioned by the late war; and his first great error and limitation lies in the fact that he has uncritically accepted the war neurosis as a sufficient orientation point in psychopathology generally. From this source, for reasons which we shall examine later, he has contracted a sufficient number of prejudices and unsure *points d'appui* to undermine completely his comprehension of the transference neuroses and the major dissociative disorders. He has had no contact at all with the phobias, the compulsions, or the conversion hysterias of civilian life, nor with the schizophrenias, or the cyclothymic and epileptic phenomena. These latter he seems to know chiefly from reading, and most of his material on these subjects, on which the main body of psychoanalytic theory and practice were evolved, is borrowed. Concerning his personal contact with the psychoanalytic method, we are told that he has had some personal analysis with Jung, though from his understanding of the dynamics of Freudian psychology, we must infer that it was not a very searching affair.

Now, the continuous trotting out of the war neuroses as a basis on which to criticize Freud threatens for a while to become a veritable Trojan horse. A great many of McDougall's objections to the dream theory, to the theory of regression, to the specific mechanisms of the neuroses, to the Œdipus complex, to the pleasure principle, and so forth, come from this source. In this regard he differs in no way from at least one other noteworthy student who also made the war neuroses a point of departure—Dr. W. H. R. Rivers. McDougall's constructive suggestions lie in the same direction as those of the late Dr. Rivers, though they are not nearly so keen. What Dr. McDougall says about the war neuroses is not so wrong, as far as he goes. The rub lies here—that he falsely assumes that all functional disorders

must be based upon the same mechanisms and principles, that he permits of no varying distribution of the factors that cause them. The reviewer's criticism is based upon four years of constant occupation with the chronic forms of the war neuroses, or traumatic neuroses, as they ought more properly to be called. But, unlike Dr. McDougall, the reviewer was impressed with the difference in symptomatology, psychological fabric, mechanisms, secondary character traits, and psychological affiliations of the traumatic as contrasted with the transference neuroses; yet he has never found occasion to question the orthodox Freudian method with regard to the transference neuroses, nor found the libido theory wanting. In short, the traumatic neurosis and the transference neurosis are two different diseases; the traumatic neurosis is not a transference neurosis, and conclusions drawn from it do not vitiate the libido theory—in fact, they supplement it.

We first begin to hear about the traumatic neuroses in connection with dream psychology. The dreams in these latter cases, claims McDougall, disprove the Freudian contention that all dreams are repressed wishes with a sexual root. The dreams in a traumatic neurosis, says McDougall, are simply "reproduction dreams"; they reproduce some incident in the past. The true explanation, according to McDougall, is that in this type of neurosis the *fear instinct* becomes more excitable—that the motivating power of reproduction dreams is more often fear than any other conative force, firstly, because of the great *strength* of the fear impulse, and, secondly, because fear is an affect which we repress under the tradition that to feel or to show fear is a sign of inferiority. The war dream expresses, therefore, a simple law of our affective life. *Sic!*

Concerning repression, from the war neuroses McDougall has learned that one may repress by direct conscious effort. The amnesias, paralyses, tics, and fugues in the war cases are merely in the nature of "simple dissociations". His illustrations of fears and anxieties and symbolic symptoms are drawn from war cases, where indeed symbolizations and displacements are but feebly removed from their origin. All of this proves that Freudian contentions concerning the mechanisms

involved are extravagant. In the war cases McDougall finds evidence to prove that regression is not a retracing of the ontogenetic development of the erotic instincts. In the discussion of tics and stereotyped movements, we are again confronted with four typical and valid cases of traumatic neuroses, and these are held up to show that the Freudian psychology of conversion hysteria is all wrong. It is also interesting to note that in the discussion on phobias and compulsion neuroses, the author illustrates with material borrowed from other authors; but none of these cases are traumatic cases. And for this we may offer a simple explanation: in traumatic cases we rarely encounter the typical phobia and never the compulsion neurosis. Why?

His experience with the treatment of war cases likewise prejudices McDougall against psychoanalysis as a therapeutic procedure. Abreaction and hypnosis should be useful on general principles because they are useful in traumatic cases; "there is insufficient ground for the holy horror of hypnosis displayed by so many analysts".

To say that the work of a psychiatrist is colored to a large extent by the specific material that he handles is by no means a disparaging charge; it does not damage Freud in any way to say that his conclusions were colored to a large extent by what he encountered in the transference neuroses. The principles that he worked out in these diseases may be used in a pragmatic way upon diseases which permit no direct application of the method of psychoanalysis. The traumatic neuroses are one of a series in which the analytic method has been able to make but little headway. It is indeed significant that Freud in his latest work (*Hemmung, Symptom, und Angst*), complains that to date no single noteworthy analysis of a traumatic neurosis exists. The same may be said of all the "*actualneurosen*", or physio-neuroses as they may be called—to wit, the anxiety neurosis, neurasthenia, hypochondria, and another disease which is rather isolated in psychoanalytic nosology, idiopathic epilepsy. We can confidently state that no one has written anything on these diseases that seems to have struck the main stem of the disease process; what does exist seems to be concerned with some of their epiphenomena. All these diseases, especially the traumatic neuroses, have in

common the fact that whatever the instinctive origin of these respective conditions may be, they show themselves clinically incapable of transference and displacement. In the case of hypochondria, the lack of transferability depends upon its narcissistic character; with the other conditions above mentioned, the reason for the incapacity for displacement is more obscure. With this character of poor transferability, there is a corresponding poverty in symbolization and sublimation mechanisms. Thus the symptoms of the traumatic neuroses do not diffuse themselves and are not, if one may call it so, diluted through a whole series of displacements. The work of repression in the traumatic neuroses is, therefore, more direct and in consequence much more difficult. The traumatic neurotic enjoys, in comparison with the transference neurotic, infinitely less leeway; his neurosis is, in a way, more difficult to escape from. The predominant mechanism in the traumatic neurosis is a periodic reiteration in undisguised form of the traumatic event, with a series of defenses and secondary character formations. The transference neurosis is likewise dominated by a continuous reiteration process; but instead of being undisguised and photographic, the instinctive urge is displaced, symbolized, transferred, sublimated, and expressed in an infinite number of ways, all of which facilitates the escape from the repressed material. It is, moreover, a noteworthy fact that the regressive process in the true traumatic neurosis rarely takes in the sexual organization of the individual. The reasons for this we cannot pause to explain. We must parenthetically remark here that by traumatic neuroses we mean those neuroses in which the trauma imparts its specific character to the disease and not those in which the trauma serves as the occasion for releasing a long-latent psycho-sexual conflict. These latter cases are in all respects ordinary transference neuroses.

The work of an analysis in a traumatic neurosis is, therefore, markedly curtailed because the neurosis, as it exists, has but a very thin psychological superstructure; it does not accumulate any new appendages with time, though it may have a chronicity of eight years or more.

It is this character of the disease—namely, its non-displaceability—that explains the compact and photographic char-

acter of the dreams, and that also explains why the method of hypnosis is so effective in treating them. The work of hypnosis is relatively simple. One needs to recover only the traumatic events and to reunite them in the patient's conscious memory. This procedure by no means cures the patient. Moreover, the reviewer has never found it necessary to hypnotize a subject with traumatic neurosis and prefers to work through a conscious level. The traumatic event leaves so many clues behind in the symptoms that it is rarely necessary to learn its character through hypnosis; one can recover the amnesias by a direct method even more effectively. The conscious procedure, moreover, offers a much better opportunity to utilize the libido transference in an active manner. But even if we grant that hypnosis is effective in traumatic cases, how can one urge that hypnosis should be more frequently used in the transference neuroses? In the latter type of disease, one cannot go so directly to a specific traumatic event because even if one does, one leaves the resistances attached to all the displacements, secondary repressions, transferences, and symbols of the repressed material. To argue thus is to misapprehend completely the manner in which a transference neurosis is built up and to misunderstand completely the nature of psychoanalytic therapy.

A still more important clinical and pathological difference between the traumatic and transference neuroses lies in the defenses which the respective patients erect against anxiety and, indeed, in the way in which the whole anxiety problem is handled in both conditions. In every traumatic neurosis one witnesses an effort at repressing the unbearable anxiety, and displacement is one of these mechanisms. However, the transferences and displacements in traumatic cases are *extremely feeble* and most easily recognizable. Where the anxiety is completely mastered, successfully repressed, it is usually done at the cost of much more troublesome symptoms and the disease picture comes more and more closely to resemble that of epilepsy. In extreme instances, the traumatic neurosis is indistinguishable from epilepsy. In other words, the nature and disposition of the anxiety follows not at all the same patterns as the transference neurosis, a fact

which makes one suspect that, despite superficial resemblances, the two diseases differ profoundly.

Furthermore, the secondary character traits of the traumatic neurosis have no resemblance whatsoever to those encountered in the transference neurosis. The *locus* of the conflict seems to be in an entirely different direction. That a predisposition to one disease has nothing to do with the other was remarkably demonstrated by two soldiers, both of whom had had severe transference neuroses prior to service and were subjected to those very conditions which usually form the basis of traumatic neuroses. During service both these men were entirely free from symptoms; but on returning home they went back to their old hysterias without so much as a trace of any of the phenomena encountered in traumatic neuroses. We do not wish to give the impression that these two diseases are very *sharply* demarcated from each other. The absence of displacement and symbolization exists in varying degrees, though in no instance do these mechanisms achieve the remoteness from their instinctive source in the traumatic that one finds in the transference neuroses.[1]

The reviewer is not attempting to discuss here the dynamics of the traumatic neuroses; he is not prepared on this occasion to state whether or not this clinical difference both in (a) mechanisms, (b) secondary character formations, and (c) psychopathological affiliations, indicate that the traumatic neuroses depend upon a different instinctive urge from the transference type. He does, however, believe that the psychology of the traumatic neuroses constitutes a vindication of the libido theory, and that this need not necessarily be along the lines made in 1918 by Abraham, Ferenczi, Simmel, and Jones. This discussion is merely to show that McDougall's arguments against Freud, based on the traumatic neuroses, rest on an entirely false assumption. McDougall has nothing to say about the traumatic neuroses that is new;

[1] The word transference in psychoanalytic usage may have the meaning of libido cathexis or displacement. In this discussion the receiver wishes to indicate that the traumatic neurotic has a capacity for a libido transference to the physician, but is incapable of displacing the neurosis either on the analytic situation or on any other situation.

what he does say is not wrong, but he has made very hasty use of his data and has shown himself thereby to be very poorly oriented on even the descriptive features of the transference neuroses.

For the purpose of contrasting the traumatic and transference neuroses, we present the following two cases: (1) a typical traumatic neurosis in which the presenting symptom is a conversion hysteria, and (2) a transference neurosis in which the presenting symptoms are a series of tics.

The first patient, a man of thirty-six, complained of feelings of numbness, pains, coldness, and sweating from the waist line down to his toes. The sweating, he said, was more or less continuous. His symptoms were about seven years old. Other symptoms were marked irritability, instability of temper, tendency to aggressiveness and pugnacity, spells of transient blindness, and vertigo. He had the typical nightmares of traumatic cases—dreams of drowning, of being run over, of being burned alive, of being shocked by electricity—and occasionally he had dreams of fighting, in which he was the aggressor.

Spontaneously, he referred to no shock or trauma, but when asked whether anything had occurred to him in service, he stated casually that he was on board the *U. S. S. Lincoln* when she was torpedoed. When he was pressed to tell more about this event, he showed the usual reluctance to continue any discussion, although what he had said was without any particular affect. As he continued to talk, there was a mixture of anxiety and anger. The facts were that he was submerged in the water for about twenty hours on a raft and he was almost drowned, but he does not remember being very panicky or frightened at the time. When it was pointed out to him that the symptoms he complained of were very like those he must have had while submerged in the water, he readily agreed. He then told me that when, in the past, he had closed his eyes and permitted himself to think of these sensations, he had often imagined himself clinging to the raft.

The symptoms represented, therefore, a hallucinatory reproduction of the original sensation of being submerged in the water. It is not necessary to go into any further details about the symptoms. No cure was effected. There were many

breaks in the man's adaptation, but there was no evidence of any psycho-sexual conflict either in his dreams or in his productions, and he was in no way adapted to analytic technique. He never spoke of anything outside of his symptoms. The dream life and the symptoms, therefore, show the complete absence of displacement mechanisms and a great abundance of reaction formations directed against the external environment. In back of the presenting symptoms there lies merely the repressed traumatic event.

The transference neurosis concerns a boy of fourteen who was brought for treatment for a series of tics which had recurred off and on for five or six years. These tics consisted of a jerky movement of the eyes to the left and back; a spasmodic closing of the eyes; a movement of the head over the left shoulder and rapidly back; a group of mouth tics; a licking of the chops; a clicking noise with the tongue; inarticulate guttural and labial sounds; and, finally, a spasmodic swallowing.

The parents stated that he was an agreeable boy, liked by his friends, popular at school; that he got on well with both parents and with his younger sister. He had never had any disorder of conduct. The family history was negative. For several years the boy had been treated for obesity, his weight at thirteen years of age being about one hundred and sixty pounds. He was diagnosed as a case of endocrine disorder, but the sella turcica was normal. He was treated for his obesity and tics by suggestion, glandular extracts, sedatives, and change of environment, all without permanent avail.

When asked about his symptoms, the boy stated that he had no knowledge of when or how they began, that he had no control over them, and that they were periodically aggravated without apparent cause. Conscious difficulties in adaptation came from only one source—namely, a masturbation conflict. This practice he had continued since the age of nine, at first without fantasies, but after the age of thirteen, with a fantasy of coitus. He had struggled very hard to discontinue the practice because he knew that it was wrong and because he had read that it caused insanity and that as a result thereof one could not have any children. This masturbation conflict

had been more severe several years before, but was still quite intense at the time of contact.

The patient was casually told that if he had any dreams, he was to report them. Whereupon, he volunteered that there was one dream which he had had repeatedly from the age of four to seven, that it was an anxiety dream which he could remember because it was always the same dream. It was as follows: "I am in bed and a large, round object keeps coming closer and closer to my face, and just as it is about to strike me, I wake up." The patient immediately volunteered to interpret the dream: "This dream has something to do with eating." He said that he had had this dream most often when he was put to bed by his nurse after the noonday meal, and that he would often wake out of it crying and would call for his mother or his nurse, and she would put him to sleep again. He first began to have these dreams shortly after the birth of his little sister, as a result of which he was removed to another room and made to sleep alone; and he also remembers that, though he always went to bed with his favorite teddy bear, on this occasion he threw the teddy bear out of his bed and refused to sleep with it. The conversation that followed showed the boy's interpretation to be correct. The mechanism of the dream was quite typical. He yearned in the dream for an object with which he once associated a great deal of pleasure. This yearning he was obliged to repress because his place had been usurped by his little sister. The huge object that he longed for was the maternal breast. There was no history of prolonged thumb-sucking; but since the age of five, the boy had shown a voracious appetite. He not only gorged himself with food at the table, but would frequently rob the cupboard. As a result of all this enormous intake of food, he began to grow very stout. About this time, age six or seven, he developed a kleptomania, but the objects he felt compelled to steal were food objects.

The obesity troubled his parents and began to make him an object of derision among the boys in the street, and it was, therefore, under great resistances that he was able to continue gratifying his lust for food. The derision of the boys in the street seems to have been more effective than the warn-

ings of the doctors. At all events, food began to become less accessible to him as a means of gratification.

About that time the tics began to show themselves. The first tics that he showed were the inarticulate sounds with the lips and pharynx. The boy's father knew what these sounds were. They were colloquial swear words and colloquial expressions for coitus. The boy was, however, unwilling to let the people around him know that he was using these obscene words. He finally disguised them so that they degenerated into unrecognizable guttural and labial sounds. The licking of his chops and the swallowing were quite obviously motions connected with the taking of food.

In short, we have here a whole series of oral-erotic substitute gratifications, all of which were compensations for the loss of the original mother breast. The surrogates for the breast progressively took the form of an enormously increased appetite for food, kleptomania for food objects, articulation of obscene words, and, finally, imitations of the act of swallowing.

The relation of the Œdipus complex to the symptoms was beautifully illustrated by a chance event in the course of treatment. The family was stopping in a hotel, and one day the father had to return to his native city. The boy was thus left alone with his mother. Two days after the departure of the father, the mother became quite dismayed and wondered why the boy's tics had become so much more severe during the past few days. On this interview the patient was extremely reticent and said that he did not know of any reason why his symptoms were aggravated. He finally broke the silence with a question which was to this effect: he wanted to know why he was able to see the reflection of his mother's activities in the bathroom and to see her exposed without any interest, whereas whenever he saw the parts of any other woman exposed, it excited him greatly. He then proceeded to narrate how his eye symptoms had become particularly severe in the last few days. He was also able to recover the first occasion on which he had seen his mother exposed, at about the age of six, and how he debated with himself whether he ought to look around or turn his head away. He had the same feeling later

when he visited the museum and saw the figures of nude women.

In short, the neurosis consisted of an effort to escape from a conflict in the present, which took the form of a guilt feeling about masturbation. The inability to find adequate outlet in this manner caused the patient to retrace a path which was most easily followed through his symptoms and was seen to depend upon a hunger for oral gratification. The hysteria, therefore, represented a compromise formation—a substitute for the desired gratification, with certain checks upon it. In back of the presenting symptoms there was, therefore, a rather elaborate psychological superstructure, a desire or urge which was blocked in its expression.

In the traumatic neurosis we observe a fixation on a traumatic event; the patient's symptoms are (1) a photographic living reproduction of the sensations he had while submerged in the water; (2) dreams which are not necessarily photographic, but in which there is constant reiteration, with some variety, of a threat to the patient's existence; and (3) reaction formations in the form of a defensive attitude to the environment. In the transference hysteria there is a fixation on the oral zone, with efforts to gratify it with a whole series of different activities—eating large quantities of food, playing with his tongue, obscene words, and attempts to check and disguise them. The gratification is archaic and is called upon as an escape from the sexual conflict involved in masturbation and in the Œdipus fantasies implied. The symptoms represent a compromise, in that the gratification and the checks upon it are written into the symptoms. In this simplest type of transference neurosis, the erotic motif is not difficult to recognize; in the traumatic neurosis we deal with a reaction type which has a less direct connection with what represents itself in consciousness as the conation of appetite, desire, or quest for gratification. This latter character of the traumatic neuroses was conceded by Freud in 1921 (*Jenseits des Lustprinzips*).

In the remaining criticisms of Freud we are now in a position to know what to expect from Dr. McDougall, and we are not disappointed. He simply discards all that appertains to the transference neurosis and retains only the instinctive

principle which he calls by the name of "hormé". He retains the principle in a purely descriptive sense. The pleasure principle, pregenital sexuality and narcissism, and fixation regression and resistance all go by the board; the specific mechanisms of the neurosis, the principle of defense, reaction formation, sublimation, and substitute formation all follow suit. What is retained of Freud's terminology has its connotation so altered that it no longer has a right to the names originally used by Freud.

Toward the subject of the sexual instinct, McDougall has a purely behavioristic stand; that is, he recognizes nothing as sexual but what is directly connected with the copulatory process and the external genitals, and does not investigate the developmental aspects of sex except in so far as the genitals are directly concerned. Naturally, the entire sexual theory occurs to him as a piece of "mythology". In reply to Dr. McDougall's clamor for a scientific proof of the existence of pregenital sexuality, we can suggest that he be not so ready to accept the lay connotation of the word "sexual". Naturally, if one asks lay people: "When did you first have sexual feeling?" they will all uniformly refer to the manifestations of puberty. We suggest that Dr. McDougall inquire about the sexual development of certain people who would reply to such a query: "Why, I never had any sexual feelings and I haven't any now." Dr. McDougall would certainly not sanction the idea that the sexual instinct does not exist in some people or could never be awakened. We suggest, therefore, consideration of the following data:

A young man of twenty-two years was sent for the treatment of an apparently simple condition: he had from time to time stated, within the hearing of his father, that he did not believe in sexual relations, that they were wrong, unethical, and so forth. He had shown occasional erraticisms of behavior toward his mother and sister, but was on much better terms with his father. For several years he had picked severe quarrels with his mother on minor provocations, and was at times very erratic and unreasonably rude in his behavior. Besides this there were no symptoms of note. His father sent him to a physician to have some of his "sexual ideas straightened out".

The patient stated that he had, until a year prior to his visit, believed that sex was wrong, but that he had been led, by its general acceptance in society, to think that he was not entirely right in his former belief. He accordingly decided to change his attitude. Prior to this time (age twenty-two) he had never had any sexual experience of *any kind*. He had never *masturbated* in his life and had rarely had erections, and when he had, they were at no time connected with the usual stimulus. Physical contact with girls in dancing was repulsive to him; on the few occasions when he had kissed a girl, he had found the act disgusting and had to leave the room *"to spit"*. He had never found any part of the female attractive except the buttocks, though he had never associated this interest with anything sexual. He had never had sexual fantasies, and the sight of a nude female, on such occasions as he had deliberately sought, had excited him not at all. When he had twice attempted, under the influence of his altered attitude toward sex, to cohabit with a prostitute, he had not only failed to get an erection, but had found the contact disgusting. We have here an individual who may quite correctly be described as having no *sex life* either directly or in sexual fantasies. Moreover, deliberate attempts at genital masturbation with fantasies gave no erection or gratification.

This notwithstanding, the patient presented evidence of a severe disturbance in his emotional and social life. The first question to answer was: Where is his sexual instinct? He was interested in athletics and jazz music; beyond these there was no evidence of sublimation. The answer came by accident when one day in the office he complained of an irresistible impulse to put his hands to his head and to stroke it gently and repeatedly. This, he said, he did a great deal of the time when he was alone. And when I inquired about his childhood habits such as thumb-sucking, he replied without any affect that he had never stopped sucking his thumb since infancy and that at no time in these eighteen years of conscious recollection could he remember a time when he had not gone through a certain ceremony in connection with the thumb-sucking. This consisted of burying his head in a pillow, sticking his right thumb into his mouth, and with his left hand kneading the pillow. He practised it chiefly at night, and, in fact, used

it as a hypnotic. Occasionally during the daytime, in response to some indescribable urge, he had to stop whatever activity he was engaged upon and retire to some private place where he could thus indulge himself. It was a secret practice, used as a hypnotic, a protection against vague dreads and somatic sensations of an indefinable sort. What gratification there was in this practice he described as "a frenzy of enjoyment". He had never had a guilty feeling about it, and had never been punished for it.

A day or two later, in reply to the question about his dream life, he became much embarrassed. After a prolonged silence, he said that he had had a dream the night before in which he was giving himself an enema. This is the history as he narrated it: "I have always enjoyed cleanliness. When I was about eleven years old, another boy and I were in the bathroom, and he suggested that we cleanse ourselves. Ever since then I used to give myself enemas, three or four times a week. I enjoy the sensation of the water flowing out. It is the most stirring sensation in the world; it takes me out of myself. It would cause a trembling and finally a relaxation as if something gave way—and I felt so fine after it." His nocturnal pollutions were always accompanied by enema dreams, and several times in the act of douching his rectum he had had ejaculations, which had led him to suspect that this was a pseudo-sexual activity. (Incidentally, all his quarrels with his mother were on the subject of cleanliness.)

One year prior to treatment, he developed a choking sensation in the throat, spasmodic and frequent. Its coincidence with efforts at heterosexual activities is significant. Moreover, there was an effort to stop anal activities. (His dreams confirm this.) During this time he became subject to strange, indescribable visceral crises, located intra-abdominally, in joints, muscles, and so forth. In addition, he was from time to time subject to wild outbursts of activity, hilarious laughing, dazed and confused episodes, and finally preoccupation with a ray theory—to the effect that all people and animals must have rays emanating from them—and he was beginning to interpret his somato-psychic sensations as due to their influence.

We have here a case in which we need not look for any

erotic regression; it is not a perversion, but a simple fixation on two erogenous zones—mouth and rectum. As long as he could remain in this state, there was no break in his adaptation; the trouble began only when he was obliged to make some inroads on this activity and to replace it by another more in conformity with the ideas of the group. His conscious efforts at heterosexual activity were perfunctory and failed for much the same reason that "words without thoughts do not to heaven go". It was natural to suppose that with the suppression of the activities connected with these zones, he had either to go toward heterosexual activities or to devise some equivalent for those that he repressed, equivalents that had some direct or implied conation of pleasure. The latter course is, indeed, more natural and accessible; there appear in lieu of the suppressed activities a hysterical choking, the strange visceral crises, and finally a system of thinking which brings these psychological equivalents of auto-erotic activity into some logical relation with the world, a process very characteristic of schizophrenia.

The question, therefore, as to whether or not these activities at the mouth and rectum are *sexual* remains an academic question. Clinically, it is of no consequence. Clinically, one can see that the activities are in response to an instinctive need, to an urge which is conated as gratifying, for the achievement of which the individual pursues a purposeful activity or devises some psychological equivalent thereof. Theoretically, it is of great importance to establish the relation of these erogenous-zone gratifications with other holophilic activities. One cannot enter here into the other problems suggested by this case. It is advanced merely to show that the conventional standardizations of words are poor guides for scientific thinking, that the purely behavioristic approach leads to a host of disjointed and detached entities. If these anal and oral activities are not erotic and are not ontogenetically related to the sexual instinct, it is up to Dr. McDougall to deny their existence or to classify them as self-assertive or submissive instinct activities, and to describe the patient as hopelessly dissociated and disintegrated.

Concerning the pleasure principle, Dr. McDougall objects to it because it belongs to "a system of psychological hedon-

ism''. This statement is supposed to be self-explanatory. We suspect that his objection comes from a metaphysical basis, all of which has nothing to do with the clinical usefulness or the subjective truth of the principle. Freud has in all his work accepted the pleasure principle on a pragmatic basis; it is the name of a *predominant direction* of certain psychic processes. Freud, as McDougall correctly observes, has admitted the existence of other principles, one at least which he designates as the *''Wiederholungszwang''*. The reviewer has, moreover, observed psychic processes which have a less direct connection with what represents itself in consciousness as the conation of appetite or desire, yet they are instinctive. This does not, however, vitiate the pleasure principle as it is used by Freud; its validity is established not on metaphysical, but on a subjective basis.

Of the words repression and suppression, unconscious and subconscious (which he uses synonymously), McDougall has only a descriptive understanding, not one that is dynamic and topographic. He laments that Freud never uses the words dissociation and disintegration in the sense in which they are used by Morton Prince and Janet. The difference lies here. Repression is the name of an active, living, and purposeful process; the success that it has varies. Where it fails, the repressed material returns in another form, the symptom. The symptom, therefore, appears to be ''dissociated'' and to have an independent existence. One can use the word dissociated to designate the return of repressed material; but we know that what appears detached from the aims and purposes of the individual is still a living part of him. Thus the word dissociated is well to use in a descriptive sense, but not in a dynamic. And since Dr. McDougall does not understand the difference betwen the two points of orientation, the words suppression and repression, unconscious, subconscious, and co-conscious connote the same thing.

Of the Freudian concept of regression McDougall gives the usual travesty, describing it as a process whereby ''the patient becomes dominated by the sexual desires of his infancy''—again using the word in a descriptive sense and proving his point by several cases of war neuroses. The reviewer has already demonstrated the differences between

the transference and traumatic neuroses; he is ready to concede that the regression in traumatic cases rarely takes in the psycho-sexual development. What Dr. McDougall says about regression in traumatic cases may be true provided that he permits it to apply to such cases only. We may furthermore add that the types of regression seen in traumatic cases—of which McDougall has several that are remarkable—do not occur in any form of transference neurosis. These are questions that need answering, but we fear it cannot be done by discarding all that we have learned about the transference neuroses.

Concerning sadism and masochism, he has, strangely enough, little to say. It has been described as a component of the sexual instinct, the ego-instinct component thereof. Dr. McDougall does not wish to understand it thus, because if he did, he could not very well say that the sadistic represents the "self-assertive" and masochism the "submissive" instinct. Sadger, over a decade ago, described the sadistic component as a manifestation of a *"Bemächtigungstrieb"* and the masochistic as a manifestation of an *"Erniedrigungstrieb";* and Freud, in 1922-23 (in *Das Ich und das Es* and *Das Ökonomische Prinzip des Masochismus"*) conceded that sadism and masochism represent instinct mixtures. Such sadistic and masochistic components, says McDougall, "can only be justified if the behavior in question can be shown to be common to all members of the species . . . there is in animal life nothing corresponding to the human tendencies known as sadism and masochism".

The fact can be verified by ordinary clinical observation of how completely the sexual organization and egoistic attitudes in man can be reciprocally influenced, and by observation of animals. Perhaps one illustration from animal life will suffice. We commend to Dr. McDougall's consideration the observations made by G. V. Hamilton concerning the relation between egoistic interests and sexual attitudes in monkeys. Hamilton tried the experiment of placing two monkeys of the same sex, but of unequal size and strength, into the same cage. He observed that in each instance the larger and stronger monkey would attack the weaker one, and that the latter would invariably assume the attitude of the female in the sexual

act. The larger monkey would also go through copulatory movements. He then took the weaker monkey of this experiment and placed him in a cage with another monkey of the same sex, but one who was in turn weaker than himself. Whereupon, he observed that the monkey which in the former experiment took the feminine and submissive part now took the aggressive and masculine part, and the weaker monkey the feminine part. To be sure, this is no illustration of sadism or masochism in monkeys, but it does illustrate the reciprocal relationship between sexual attitude and egoistic expediency.

Let us turn now to Dr. McDougall's thesis: His argument is extremely difficult to follow, and its sequentiality rather dubious. In order to understand the more serious departures from normal, we must understand the slighter ones, and he thus studies (1) fatigue, (2) dreaming, (3) the influence of drugs, and (4) hypnosis. He knows that two of these involve a dual problem, physiological and psychological, and he does not attempt to explain one by means of the other. He finds that fatigue and alcoholic intoxication are governed by similar principles. "The degree of fatigue or of alcoholic intoxication, as indicated by the objective and subjective symptoms, is the expression of the relation between, on the one hand, the amount of free active energy at work in the nervous system and, on the other hand, the inhibiting and blocking factors which have to be overcome in order that the free energy may express itself in bodily or mental work."

In attempting to solve the psychological problem connected with fatigue and the process of falling asleep, McDougall gets his cue from a simple observation. A dog is dozing on the rug, something happens, and he becomes active, energetic, showing marked changes in behavior and emotional tenor. What has happened is that some instinct has been aroused. "When some instinct is brought into play, the animal becomes emotionally excited. . . . Each instinct seems to be in some sense a great reservoir of energy. . . . " And this led McDougall to the hormic theory of human and animal nature.

The word "libido" in the Freudian or Jungian sense he rejects and substitutes the word "hormé", which has the connotation of "force, attack, press, impetuosity, violence,

urgency, energy, zeal"; it is very like the Bergsonian *"élan vitale"* and is incompatible with the "pleasure principle". The instincts are the foundations of the structure of the mind. There are a group of primary instinctive dispositions; of these latter we hear more of the instinct of self-assertion and submission than any of the others, though the sexual instinct is recognized as such a primary one, separate from the parental instinct. Each of these primary instinctive dispositions may "give rise to a number of systems of secondary dispositions which remain connected with it and actuated by it; and any one such system of dispositions concerned with a particular object or class of objects together with its coöperating and actuating primary disposition . . . constitutes a *sentiment* or *complex*". "The impulses of the various instincts may coöperate, combining their energies in the support of one train of mental and bodily activity, in so far as their goals are not incompatible with one another. And normal mental development largely consists *in the development of such mental structure as facilitates the harmonious coöperation of the instinctive tendencies,* the growth of the sentiments being the main feature of this development. But primarily the impulses or conative energies of the several instincts tend to *conflict one with another,* the stronger inhibiting the weaker. . . . The work of character formation is the organization of the sentiments, under the dominance of *the sentiment of self-regard.*"[1]

In place of the Freudian ego, ego ideal, stands the "sentiment of self-regard" (or "self-respect"!). This sentiment is the organizing and critical force, the repression force, dream censor, and so forth. "The repressing force is neither the pain nor the disagreeable affect itself [it is implied that this is the Freudian position!]; it must be some other affective force of the personality . . . the repressing forces must, I think, be looked for within the sentiment of self-regard." The incompatibilities created in the sentiment of self-regard —conflict—resolve themselves by a process called dissociation, which holds a variable relationship to repression. The relationship between dissociation and regression is nowhere made clear, but at all events McDougall believes in this mechanism,

[1] Italics the reviewer's.

though it is hard to see where it fits in. Regressions are not of the nature that Freud describes. It is more than "an abeyance of the higher functions, those last developed phylogenetically and ontogenetically"; it is "abeyance of all the functions of associative reproduction", involving at times the whole cognitive structure of the mind. Regression is most frequently initiated by shock or fear; and conflict is conceived of as being *waged between the instincts.* (Freud has overlooked this, McDougall claims.)

A well-knit character is one that can resist all disintegrating forces, "and this capacity depends upon the organization of the sentiments in an ordered system dominated by a master sentiment. . . . In the more extreme instances of disintegration, this master sentiment undergoes actual disruption. Its two fundamental impulses or dispositions, that of self-assertion and that of submission, become divorced and each forms the nucleus of a partial one-sided personality."

McDougall can now form a hierarchy of dissociative disorders, from those that are superficial, occurring at the upper levels of the total cerebral organization, down to those in which the dissociation is most profound, taking place at the level of the most deep-seated functions, the instinctive tendencies. The simplest dissociations are simple anæsthesias and functional paralyses. Then come amnesias; then multiple personalities.

Let us now see how Dr. McDougall applies this thesis to clinical problems.

To take up first the question of *hypnosis,* Dr. McDougall knows that his theory of cerebral dissociation offers no basis to explain the *"rapport"* between hypnotist and subject. To explain this factor in the potency of suggestion, he looks for an instinctive basis, but rejects the masochistic sexual element of Freud and Ferenczi. Judging from the behavior of animals, there is an instinct of submission, which must also be present in man. This submissive impulse is the main conative factor at work in all instances of true suggestion. (This, incidentally, has nothing to do with the much-tooted herd instinct.) If it were not for this submission instinct, human beings would not be suggestible, and their social life would be very different. If we continue this line of reasoning, it is easy

to see that the person who offers the suggestion is dominated by the instinct of self-assertion. The susceptibility to hypnosis depends on the native strength of the submissive instinct and on the proclivity to dissociation. The extrovert is more liable to dissociation, and is hence more readily hypnotizable, than the introvert. "If Freud had recognized that the tendency to subservience . . . is rooted in an instinct distinct from and independent of the sex instinct . . . he would at once have reached the theory of suggestion proposed in my *Social Psychology.*"

Automatisms, fugues, hysterical fits, somnambulism are in the nature of simple dissociations, and due to the activity of a subsidiary mental stream, which Morton Prince designated as a co-conscious state. How this comes to pass we are not told.

Concerning anxiety states, McDougall is inclined to think that repression, dissociation, and amnesia have little to do with the neurosis. He quotes Dr. Gibson: "In almost every case the cause of the neurosis is interference with the primitive instinct of flight which has as its affective accompaniment the emotion of fear." These explanations, says McDougall, will save the general physician from being carried away by extravagant theories and from the wilderness of fanciful speculation.

The Freudian explanation of conversion hysteria he likens to putting a pound of pork in at one end of a mechanism and getting it out in the form of sausages at the other. His own explanation is this (in his discussion of pain as a conversion symptom): "bodily pain arises when nerve currents are excited which do not follow any preformed system of channels in the brain. . . . If, then, a severe emotional shock . . . is evoked at the moment of some bodily activity, the energies liberated, incapable of finding natural outlets in bodily action and expressions, overflow into the system of neurones in action at the moment, and produce within it . . . some maladjustment that endures as the ground of the subsequent pain referred to the part in question."

Concerning phobias, he regards them as due to traumatic events in childhood which evoke self-reproach, shame, or guilt. Such shock or fear causes dissociation; the fear persists, but

the event is forgotten. The phobia is, therefore, the expression of a *repressed,* rather than a *dissociated,* symptom.

Manic-depressive psychosis is due to a disturbance of the normal balance and coöperation of the self-assertive and submissive impulses within the sentiment of self-regard. This normal balance may be upset by reverses or by changes in bodily metabolism. These two instincts may have specific hormones, as have the sex instinct and the fear instinct, and endocrine secretions which are liberated and favor the activity of the corresponding instinct. The disease consists, therefore, of alternating excesses of the self-assertive and the submissive affects.

In schizophrenia the self-regarding sentiments are strong. "There is no lack or weakness of the *self-affects,* the emotions and impulses of the sentiment of self-regard"; rather, they are stronger than all others in the schizoid. He "is characterized by an undue touchiness of the self, together with an incapacity for normal emotional *rapport* with other persons. Now, the maintenance of normal social relations, normal *rapport,* is rendered possible only by a balanced harmonious development of the sentiment of self-regard." Social relationships McDougall describes as oscillations between assertiveness and submissiveness. The negativism of the schizophrenic is an extreme manifestation of his incapacity for volition or decision. But voluntary decision is in turn the work of the sentiment of self-regard. Thus can anything in all psychopathology be explained. And concerning transference (in the sense of libidinous attitude to the analyst) McDougall tells us that Ferenczi's statement that the character of the transference is determined by the sexual constitution of the individual is an extreme view, and "arises from the false identification of self-assertion and submission with the sex instinct".

We do not pretend to know how satisfying all this may sound to a psychologist; but to a clinician acquainted with the history and development of psychiatric thought, it seems a most unusual mixture of naïveté and arbitrariness. We have here not a system of psychology, but a series of disconnected *psychological explanations,* which differs in no way from other explanation psychiatries based upon the endocrine

or autonomic systems. While it is true that McDougall entirely avoids any neurologizing tautology, the method is quite the same; but instead of explaining psychopathological data on a neurological basis, he now has an instinctive basis which he calls "hormic". We note, moreover, that this hormic principle is not universally applicable. Some conditions are explained as dissociations under the influence of fear, which in turn is spoken of sometimes as an emotion and sometimes as an instinct; others are explained on the aggression-submission principle. The pleasure principle being taboo, we are quite at sea as to what factors determine the oscillations of the submission-aggression about this sentiment of self-regard.

Before we attempt to assess the merits of Dr. McDougall's new formulations, it would be well to see where his methodology stands in relation to those he most severely criticizes, in particular to Freud's.

The popular notion that Freudian psychology consists of reducing all mental phenomena to terms of "sex" is the vilest burlesque. To the trained analyst Freud stands for a method and not for a series of arbitrary explanations. It is a method, moreover, that is trained on certain objectives, which are direct evolutions and outgrowths of the movement in psychiatric thought initiated by Kraepelin.

We can best survey the development of psychiatric methods from the point of view of the relationship of the psychiatrist to the phenomena he encounters in the disordered thought, behavior, and affect of the patient. To Kraepelin, who is still the great classicist of psychiatry, the symptom and the grouping of symptoms remained the orientation point throughout. The uniformity with which certain symptom groupings occurred and followed a course more or less typical led him to separate his clinical pictures into several groups. In Kraepelinian practice, the observer was detached, and what constituted a symptom was standardized against the subjective conventional criteria of normality. The whole procedure was directed toward a specific, practical goal—that of recognition and prognosis. The symptoms were merely described and their various combinations noted. Thus, Kraepelin's strength lay in that he created certain orientation points for clinical practice. There was no psychology, no biological basis

for the phenomena of the disease; though, as a general rule, somatic changes were tacitly assumed to be prominent as etiological factors, they were hardly offered as an explanation of all the phenomena of the disease, save in the frankly organic conditions.

Bleuler, though still descriptive, studied a different aspect of the symptom—not its phenomena only, but its history; and so he was able, without postulating any biological or psychological basis, to go deep into the reaction types that eventuated in symptoms. With Bleuler, then, the symptom was founded on certain behavioristic and affective antecedents and on certain characteristics in the descriptive features of the thought processes.

Freud began to work with a group of cases that were closer to the normal than those of his predecessors. He was able, therefore, to do something that they could not. With the major disorders, the phenomena of the disease, the symptomatology had to be the guide of the investigator, chiefly because the subjective conditions in patient and observer were widely different. The community of experience whereby it is possible for one person to understand another was broken; not only that, but also the capacity for mutual exchange of interest and influence was markedly impaired. In the material that Freud began to work with, the subjective conditions in patient and physician were approximately the same. This led to some remarkable results. Not only did a clinical entity, like a phobia, have certain descriptive phenomena, a morphology, a history of psychological antecedents; it had also a *dynamism and mobility.* The symptom, its phenomena and antecedents, were relegated to a position of secondary importance, according as it became evident that these phenomena represented the disease process to a very limited degree only. The symptom was observed to take on protean forms, varying with circumstances, but also to remain in contact with certain living forces and conditions. The symptom, from a psychological point of view, became less and less circumscribed, was seen to have a large number of antecedents and determinants, and was kept alive by an *instinctive drive* whose gratification was thwarted by a group of internal and external factors. And finally, Freud found that the conditions of the disease

process were susceptible to influence within the very limited situation of the relation between physician and patient. In short, the disease process and its dynamics could be observed and influenced *"in vivo"*. The transference became the screen on which the disease process was projected.

When Freud had formulated all the principles he observed in these conditions, he was able to go back to those cases in which the subjective conditions existing in physician and patient were different and to see, though to a much more limited extent, a certain distance into the dynamics of the disease process which formerly had to be described only in terms of phenomena. In other words, through what he learned in the transference neuroses, he was able to see what dynamic factors were responsible for this break in subjective continuity between physician and patient that existed in the schizophrenias and the manic-depressive group. From Kraepelin to Freud we see that clinical practice and clinical psychology were limited by certain subjective conditions which, when controlled, allowed us to obtain an entirely new conception of the disease process. The psychoanalytic method circumvented in this way the limits imposed by conventionalized introspection and avoided the obscurantism of making explanations of the disease by combining the various surface manifestations until by analogy the symptoms assumed some *raison d'etre*.

The psychoanalytic method is, however, limited by its most potent weapon—the use and interpretation of the transference. The method is inadequate for the interpretation or influence of conditions that have little or no representation in consciousness in either patient or physician. It is helpless before psycho-biological processes that have little or no ideational representation. Such a state of affairs exists in the traumatic neuroses, although in this instance the use of the transference, the influencing of the patient, remains to a large extent possible. Such phenomena arise in certain aspects of the schizophrenic, cyclothymic, and epileptoid conditions. Here it begins to be progressively more difficult to tell how much of the presenting phenomena are disease processes, how much reactions to the disease, and how much psycho-biological reaction types with no ontogenetic antecedents. For the comprehension of these phenomena other methods, perhaps comparative or experimental, become indicated.

Not the least of the Freudian contribution to psychiatry is the fact that it has offered many new points of view from which one may reconstruct even the symptomatology of certain diseases. How far one can go, with such a combination of acuity of observation and a knowledge of dynamics, is now being demonstrated by the phenomenologists in Germany, of whom Jaspers and Schilder are noteworthy examples.

There is another method that has been frequently used in psychiatry which, however, has no title to the name of a clinical procedure. This method starts, not with symptoms or with a patient, but with a principle. This monster is the interpretive or explanation psychiatry. The master principle may be psychological, neurological, endocrinological, anthropological, or combinations of them. There are many such weeds in psychiatric literature. Thus, one may explain a psychopathological entity as due to segmental cravings of the autonomic system, as due to endocrine disturbance, as part of a constitutional habitus, or, as in McDougall's instance, as due to an imbalance of the self-assertion-submission instincts with reference to the sentiment of self-regard. In this method, the observer tries to explain the phenomena of the disease by a principle which is entirely extraneous to the disease process. Its validity has no verification in subjective conditions, nor is it capable of any comparative verification. A psychological or instinctive principle may thus be used to "explain" certain clinical facts. If one posits, for example, a herd instinct, one may explain the seclusiveness of a dementia-praecox patient as due to a weakness of the herd instinct, or the egoism of the epileptic as due to the weakness of his herd instincts and the inordinate "strength" of his ego instincts. These explanations represent purely intellectualized permutations and combinations of an arbitrarily selected number of facts, and depend upon a confusion of etiological and psychological problems. Whereas some of these explanations have great merit, if used for specific instances, most of them are characterized by a breadth of generalization and a pretentiousness that is amazing. Naturally, these explanation psychiatries have no contact with clinical problems.

Dr. McDougall's original ideas belong to this latter type of explanation psychiatry. He tells us that his psychology is hormic. That is true enough. He believes that functional

disorders are due to disturbances in instinct life, but he backs up his contention with a perfectly arbitrary system in which instincts are either strong or weak, at war with one another or at peace. Somehow these things are related to a self-regard complex; the *modus operandi,* the pathogenesis, is nowhere demonstrated. He starts with two behavioristic polarities—aggression and submission—which, surely enough, abound in animal and human life. These he calls primary instincts. He then looks around to see which of the symptoms of a given disease coincide with either one or the other type of instinct. He applies this formula to all the disease entities, and is quite content with his deduction. What cannot be explained according to this principle is explained according to the descriptive categories of dissociation or disintegration phenomena. How futile this procedure is we can see when we note to what a limited extent the symptoms of the disease represent the factors that underlie it. In short, the difference between accepting a hormic principle as a basis of disorder and a psychology in which the evolution of the symptom is traced to an instinct is still a very wide one.

Dr. McDougall has leaned a great deal more heavily on descriptive concepts borrowed from Morton Prince and Janet than he has on Freud. The reason for this does not appear to be very obscure. Dr. McDougall's experience and habits of psychological thinking coincide more with the descriptive and explanatory psychologies. We do not feel that despite his acceptance of a hormic principle, Dr. McDougall has made good his professions to Freud, for no matter how much he agrees to this or that in Freudian psychology from a descriptive point of view, when he rejects the dynamic approach, he repudiates all that is truly Freudian. The soul of Freud lies in his dynamic concept of neurotic disorders and not in any specific dogma, but for the comprehension of Freud's dynamic psychology, Dr. McDougall is, we fear, too limited in experience. It is no more possible to understand Freud from the descriptive point of view than it is for a layman to understand the *modus operandi* of a dynamo from its ground plan or to learn surgery by a correspondence course.

There is more quarrel with the use that he makes of it than with the thesis that Dr. McDougall presents. The existence of aggressive-submissive trends has long been known in psy-

choanalytic thought. It was first emphasized by Alfred Adler, and though Dr. McDougall objects, the two theories, his and Adler's, are quite alike in that they both deny the importance of erotic regressions in the production of symptoms. The existence of aggressive and submissive instincts depends entirely upon the connotation that one elects for the word "instinct". However, these polarities, from a behavioristic standpoint, have a wide distribution in animal nature. The existence of such instincts, however, far from constitutes a demonstration of their activity in psychopathology. One would, indeed, like to know what is the original and ontogenetic development of these instincts. What phases of adaptation precipitate their elemental forms? What are their regressive manifestations? Such questions one must be able to answer before one can call a group of explanations a psychology.

We feel that the solution of the problem of the ego instincts, their manifestations, development, and pathology, still belongs to the future, and we do not feel that Dr. McDougall's arbitrary explanations have brought us nearer to that solution. He has chosen too difficult a task. We feel, moreover, that he has missed out on the source from which he could have derived the greatest help, from Freud, whose principles he has judged more by the letter than by their rhythm and pulse.

Although his effort to approximate the hiatus between academic psychology and psychiatry does not terminate very successfully, it must be remembered that these two different types of endeavor are stimulated by different human needs and checked by entirely different forces, and that they have entirely different traditions. Academic psychology enjoys a great deal more freedom from the severe checks imposed by clinical practice and the persistent clamor of human needs. Dr. McDougall has gone a long way toward reconciling the two methods by conceding that clinical procedure has contributed at least one principle that can be embodied in academic thinking. This is a sufficient beginning from which we can see nothing but good to come. Dr. McDougall has, moreover, set a noteworthy precedent, and has opened up the field of psychopathology to a group of students to whom it would otherwise have remained inaccessible.

RELIGIOUS HEALING*

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IN ancient times the practice of healing was carried on by the priesthood. It was a recognized function of religious procedure, and history supplies us with amusing accounts of the queer charms, incantations, and magical practices of every conceivable sort that were part of the stock in trade of the healers of those days. Such practices survive to this day among primitive peoples.

Though the early Egyptians had some knowledge of anatomy and must have known something about hygienic methods, the separation of medicine from religion and magic did not occur until the fourth century before Christ. Hippocrates, the father of modern medicine, was a product of the comparatively highly cultured Greek civilization, which made bodily perfection and health ideals in themselves.

Modern medicine itself has gone through endless changes. When we think of the numberless remedies that have been heralded, assiduously applied, and later proved worthless, in spite of their one-time reputability and popularity, we are sometimes forced to the conclusion that in the history of medicine there have been many practices, which, whatever they accomplished or failed to accomplish, must have worked through suggestion and not through any intrinsic therapeutic value. They take their place with magic. Nevertheless, the steady increase in the body of medical knowledge has tended to separate medicine further and further from religion, until at the present time we are scarcely able to trace the earlier close connection.

* A preliminary report on a survey conducted under the supervision of a subcommittee appointed by the Committee on Public Health Relations of the New York Academy of Medicine and consisting of the following members: Dr. James Alexander Miller, chairman; Dr. Robert L. Dickinson; Dr. George H. Kirby; Dr. Frankwood E. Williams; and, *ex officio,* Dr. Charles L. Dana and Dr. E. H. Lewinski Corwin. The report is published here by courtesy of the *Journal of the American Medical Association* in which it first appeared.

Psychotherapy is demonstrating the need for a more thoughtful consideration of Plato's ideal *"mens sana in corpore sano"* in the treatment of all disease conditions, and in a general way the interrelation of mind and body is recognized. But with regard to religion, a most vital aspect of mental life, opinion is decidedly divided.

A part of this particular study included gathering opinion, from a more or less unselected group of physicians, concerning the value of religion as a therapeutic agent as judged by their experience with it in practice. Comparatively few had found it practical or had had sufficient experience to warrant expressing an opinion. Of those who had had experience with it, some reported favorably, some unfavorably. The same was true in the case of those who expressed opinions on the basis of a theoretical consideration of the question.

Yet Plato's *"mens sana"* apparently meant something more than a "sound mind" as it is commonly translated, and as psychotherapy ordinarily interprets it. He[1] says: "The office of the physician extends equally to the purification of mind and body. To neglect the one is to expose the other to evident peril. It is not only the body which, by sound constitution strengthens the *soul,* but the well-regulated *soul,* by its authoritative power, maintains the body in perfect health."

To-day, medicine, freed from the church, appears to have left the care of this much disputed soul of man to the care of theology. Theology on its part has made little of the body. Some historians even contend that for about 1,500 years the church and its authorities were a hindrance to the progress of science, and that although Christ emphasized healing of the body in his ministry, during the Middle Ages especially, his followers became so perverted in their thought that they brought about untold damage to the healing art, at a most important period of its development, through their tragic undervaluation of bodily welfare and overestimation of spiritual values.

The church, however, has gone through radical changes since that time. There are those who believe that even now it

[1] Plato, quoted by G. G. Atkins, in *Modern Religious Cults and Movements.* New York: Fleming H. Revell Company, 1923. P. 98.

is experiencing a sort of continuous and gradual revolution, destined to emerge with a reversal of its former attitude toward science. Instead of looking on it as a rival, the church is beginning to welcome science as an ally and is seeking its aid in solving the problems that confront organized religion to-day.

Science, on the other hand, is said to be becoming less material, less convinced that the universe can ultimately be explained in terms of matter, and more ready to enter speculative fields.

As problems become mutual, all tend to meet in the course of their search for truth. And so it is with medicine and religion in relation to the present problem. We are not concerned with the differences between religion and science, the science or art of medicine in particular, but with what each can contribute to an impartial investigation of a mutual problem—namely, the relation of religion and health, as demonstrated in certain modern religious-therapeutic practices.

In order to comprehend the situation fully, it is necessary first to consider the theories and practices involved in the activities of certain cults, not within the church, which include healing in their purpose and give their systems a religious setting.

Then we must consider the work of individuals and institutions not especially organized for religious work, but making religion an essential element in the methods they use to readjust patients of various types who are under their care for that purpose.

We come finally to a consideration of work within the churches. This includes organized efforts to introduce healing as a function of religion, less direct efforts at religious therapy on the part of individual members of the clergy, and certain types of medical work carried on in established relationships between clergymen and physicians. To complete the picture, we call attention also to health work along more ordinary lines and the general facilities available for health work in churches.

The problem is of such complexity that it will be fully comprehended only through a most intensive study carried on with mutual understanding, mutual coöperation, and mutual

desire to solve the questions involved. This is a matter for the future. Under the circumstances, the present study constitutes only a preliminary survey of the field, and my purpose in this paper is merely to indicate the scope of the problem, to formulate conclusions so far as conclusions can be formulated at this stage, and to present what material I have been able to glean, as a basis for the formation of plans for a more adequate investigation of the entire situation. Subsequent papers will report the results of further study.

The survey has served to establish the fact that the problem is very complex and that it will repay further investigation both because of its possibilities for good and on account of the obvious necessity of preventing evil developments. Since the movement is world-wide, it was necessary to localize this particular survey, in order to make it practicable. It has, therefore, been confined largely to movements that have active centers in New York. A perusal of the literature on the subject will readily verify the fact that what is reported here is typical of what may be found throughout the country.

Its importance may be judged from the fact that the Church of England, after a study of the problems presented by the religious-healing movement, carried on over a period of three years, has appointed a permanent committee of prominent physicians, clergymen, and psychologists to act in an advisory capacity to the church with regard to the matter, and in America the Episcopal Church has also appointed an advisory committee, consisting of physicians, clergymen, and laymen. There is no doubt that the movement is on, and on in earnest.

Independent Movements

Christian Science

The most highly organized modern "faith cure" movement is admittedly Christian Science. This cult is said to comprise about 1,500,000 members. According to the statistics published in the *Christian Science Sentinel*[1] following the annual convention of the Christian Science church in June, 1925, the work founded by Mrs. Mary Baker G. Eddy, about 1870, is now being carried on by 7,220 recognized practitioners. Efforts

[1] *Christian Science Sentinel*, June 13, 1925.

are being made to secure nurses who will pledge themselves to faithful coöperation with practitioners, and there are now 216 on register. In the course of the year, 1,600 patients were treated at the newly established Christian Science sanatorium.

During the year, 3,257 public lectures on the teachings of Christian Science were given. Of these, 312 were given in foreign fields. The total public attendance at these lectures was 2,580,160 people.

The yearly receipts of the mother church were $1,075,496.33. Besides this there were gifts to the "special fund" amounting to $468,218.89; to the "relief fund", $202,103.07; to the "benevolent fund", $430,384.98; and to the "permanent fund", $17,868.08. So firmly is this movement established, both financially and in numbers, that its authorities were able to obtain property for it in the vicinity of the mother church in Boston valued at $1,305,755.47 with only $200,000 invested in cash.

Christian Science is primarily occupied with the problem of treatment. Students of philosophy and of religion harshly criticize the philosophical and religious setting which has been given to Mrs. Eddy's theories and do not recognize Christian Science either as a philosophy or as a religion.

In 1862, Mrs. Eddy, a confirmed neuropath,[1] who had been a more or less helpless invalid since her early childhood, went to Portland, Maine, to consult one Phineas Parkhurst Quimby, who, though only a watchmaker by trade, had built up a rather elaborate "mind cure" based on the theories held by the French "animal magnetists" of that time. Quimby's interest in these matters was aroused by the lectures and teachings of a magnetizer named Charles Poyen, who visited the United States about 1840.

After a few treatments by "Dr." Quimby, Mrs. Eddy appeared to be completely well. She was convinced that he had cured her of paralysis which, she believed, had been due to a lesion of the spinal cord. After her cure, she devoted herself to the study of Quimby's methods and teachings, and Christian Science is the outcome of her study. Her first publication was copyrighted in 1870, and in 1875 she published

[1] *Psychological Healing*, by Pierre Janet. Translated by Eden and Cedar Paul. New York: The Macmillan Company, 1925. Vol. I, pp. 55 *et seq.*

Science and Health, which contains the authoritative creed of the organization. *Science and Health with Key to the Scriptures* is the complete title of this book as it now appears. Mrs. Eddy devoted the rest of her life, until her death in 1910, to the advancement of Christian Science through her writings.

Certain other students of Quimby accused the founder of Christian Science of having deliberately stolen the material for her own publications from some of their teacher's unpublished manuscripts with which she was familiar. These, like Mrs. Eddy's, were curious mixtures of ideas gleaned from the Scriptures, spiritualism, clairvoyance, treatises on disease, happiness, wisdom, science, and the arts. Mrs. Eddy indignantly denied any plagiarism, and, apparently quite unmindful of the now accepted theories concerning such phenomena, claimed that her work was more than original in that it was accomplished by divine inspiration, some of it produced by automatic writing.

The main tenets of her teachings are to be found in *Science and Health with Key to the Scriptures.* The basic maxims are:[1]

1. God is All-in-all.
2. God is good. Good is Mind.
3. God, Spirit, being all, nothing is matter.

To the Christian Scientist, "matter is nothing beyond an image of mortal mind". "Disease, death, evil, sin deny good, omnipotent God, Life." Nothing is real and eternal, nothing is Spirit, but God and His idea. "Evil has no reality . . . it is simply a belief, an illusion of material sense."[2] Sickness is "error".

The "scientist" treats himself with these thoughts. He believes that pessimism leads to weakness, optimism to power. If he is ill, his self-treatment consists in dwelling on those parts of Mrs. Eddy's teachings which are appropriate for his condition, devoting his entire conscious activity or passively giving himself up to steadfast denial of the reality of the "error" to which he may temporarily be subjected. This is varied with prayer, audibly expressed or silent, and affirmations of goodness.

[1] *Science and Health,* p. 113, lines 16, 17, and 18.

[2] Quotations from *Science and Health with Key to the Scriptures.*

If unable to treat himself, he calls on a practitioner, who may help him either by absent or personal treatment. Absent treatment does not require that the practitioner shall see the patient. He may be apprised of the patient's need by telephone, telegraph, or other communication, and carries on treatment wherever he may be. Some practitioners and some patients state that they are so *en rapport* that no material communication is necessary to apprise the practitioner of the patient's need, and the patient, as through telepathy, becomes aware that the practitioner is meeting his need. The patient need merely place himself in a receptive attitude, and healing will follow as a matter of course.

When the practitioner treats a patient in person, efforts are made first to bring about the proper attitude of mind in each. The practitioner directs his efforts toward placing the patient *en rapport* with and under the control of the Divine Mind. All else must be banished from his mind. The patient must relax and banish all fear and misgiving, expect to be healed, and maintain a passive, receptive attitude.

This attitude is brought about largely by persuasion in the case of new patients, but the adept is trained to assume it with little difficulty. Treatment proper consists of reading or quoting suitable passages from Mrs. Eddy's writings, meditations, repeated denial of the reality of the patient's symptoms if he is being treated for health, with affirmations of health, perfection, goodness, and suitable prayers. The treatment may be silent, audible, or partly silent and partly audible, and may vary in length of time from a few moments to several hours. The fee for service is as a rule on the basis of free-will offering, with a tacit understanding that it shall be in proportion to the patient's means and the service rendered.

No medical help is permitted beyond attention to ordinary hygienic measures, and in her earlier teachings Mrs. Eddy deliberately enjoined against even these. A practitioner is not permitted to treat a case unless the patient has chosen between his ministrations and those of the medical practitioner. Most practitioners demand that the patient himself shall desire and ask for his services, but some still consent to attempt winning the individual at the request of others interested in him, however resistive the patient himself may be at first.

For no ailment is definite diagnosis previous to treatment considered necessary, nor is evidence of cure demanded beyond the patient's testimony. To avoid difficulty from the legal point of view, a physician is called in if death appears imminent. Christian Science practitioners are not required to have medical training, nor is there an academic requirement of any sort, beyond the acquisition of certain foundations in the technic of Christian Science treatment and personal qualifications satisfactory to the Christian Science authorities, by whom they are officially recognized.

The Christian Scientist places great emphasis on the effect of suggestion in general. He has an almost superstitious abhorrence of any negative thought, making a practice of banishing at once every idea of disease, misfortune, unhappiness, or "error" of any sort. He does not wish people even to mention them in his presence. He endeavors to create for himself a cheerful, pleasant, happy environment and to think only positive, constructive thoughts. The practitioner makes a point of demanding a cheerful atmosphere and the creation of "harmony" in the sickroom.

Besides attending their regular church services on Sunday, treating themselves or taking treatment from practitioners when in "error" of one kind or another, and attending midweek experience meetings at which they may bear public witness to the help they have received through the application of Christian Science in the pursuit of health, wealth, and happiness, the followers of Mrs. Eddy, if they are faithful, spend time in the daily study of her "word". A daily lesson based on the study of *Science and Health with Key to the Scriptures* is provided for this purpose.

A well-organized bureau supervises the publication of Christian Science literature. Lectures and other publicity are carefully planned. Two publications edited with Christian Science principles in mind—the *Christian Science Monitor,* a daily newspaper, regarded by many as one of the best dailies in the country, and a weekly, the *Christian Science Sentinel*—have a wide circulation among the general public.

JEWISH SCIENCE

Similar to Christian Science, but of more recent origin, is Jewish Science,[1] founded by Rabbi Morris Lichtenstein. New York has several active Jewish Science centers, including a prayer clinic.

"Jewish Science prayers", says Rabbi Lichtenstein, in *Jewish Science and Health,* "are always answered." Further quotations from the same source make clear the similarity between this cult and others of the same nature. The methods advocated are typical.

How to Pray.—"The Divine Mind communicates with the human mind through the imagination. . . .

"A prayer, therefore, should be offered in the form of a mental image. Man must visualize the thing he desires, he must use his imaginative powers to form his petition in terms clearly outlined in his own mind. The profound concentration of attention and thought which this form of prayer requires fills also the heart with deep earnestness and devotion. Man must pray whole-heartedly as well as whole-mindedly; he must believe in his heart that his well-being depends completely upon his prayer.

"In these mental prayers there should never be formed any negative images . . . one should see with his mental vision only the state in which he desires to be . . . he must keep the image alive and fresh, which means that this image prayer be frequently repeated, each time with greater clearness and with deeper devotion. The mind . . . must be free from doubt and hesitation and should sincerely expect a response to its supplication. The answer will not fail to come.

"One must first of all put himself into a calm state of mind . . . must free himself of all distressing thought and unpleasant feeling . . . become serene and thus attuned to the Divine Mind. Serenity cannot be achieved without bodily relaxation. Therefore one should relax completely, put himself perfectly at ease, feel no discomfort, then close his eyes and offer his prayer with the imagination. Gradually and with concentrated effort, the mind will succeed in presenting its prayer.

"Should the petitioner find himself unable to visualize his supplication, he may bring words to his assistance and offer his petition in the form of an affirmation. An affirmation is a prayer offered to the Divine Mind in affirmative terms. When one suffers from unhappiness, he affirms, 'The Divine Mind in me expresses itself in happiness.' When one is steeped in despondency, he affirms, 'I am filled with Divine hope and cheer.' In this as in the other method of prayer—that of the mental image—the mind of the supplicant must be attuned to the mood of the Divine Mind. . . .

"In both methods of prayer, the visualized and the affirmative, the supplicant must realize fully that he is declaring his desires to the Divine Mind and that his prayer will always be fulfilled. . . ."

Healing.—"The greatest gift in man's possession is health. . . .

[1] See *Jewish Science and Health,* by Morris Lichtenstein. New York: Jewish Science Publishing Company, 1925.

Because health is natural to man he need not exert himself to attain it; he need have only a care to preserve it. Health can best be preserved and life prolonged by following faithfully the precepts of Jewish Science. We say: 'Live serenely . . . avoid unwholesome excitement . . . live peacefully, and avoid anger . . . live cheerfully, avoid moroseness . . . be contented, avoid envy . . . love every one, hate no one . . . be hopeful, courageous, never worry, never fear . . . above all trust God at all times . . . wholeheartedly . . . with all your soul . . . your might . . . and you will come to know that your life is inherently a part of his essence and that your mind, therefore, is not made to be a harbor of destructive influence, nor your body a place of refuge for pain and suffering. . . .'"

"A prayer for health is offered in a manner akin to the prayer offered for any other need . . . consists of two parts: first, the visualization of divine giving and then of man's receiving; first, the process of healing; second, the state of health restored through that process.

"If any particular organ of the body is affected, the affirmation must declare that health is saturating it, obliterating all defection and suffering. . . . If the heart is affected . . . affirm, 'The stream of Divine Health is flowing into my heart, filling it with abundant health. . . .' This formula may be modified to be applied also when the ailment is in the lungs, digestive organs, liver, kidneys . . . any part of the body, care being taken to name the given part distinctly. As in all prayer, relaxation, freedom from strain and distraction is cautioned. The author further directs, 'Repeat the affirmation a number of times, slowly, without the urge of making many repetitions, but rather with concentration and emphasis on each word.'" The prayer should occupy about fifteen minutes.

Directions are also given for prayers for others, with the patient either present or absent.

"The method of praying for others is akin to that of praying for oneself. Both the ailing and the one who prays enter into deep silence. They both relax completely, eliminating all tension from body and mind. They both close their eyes; but while the mind of the patient becomes perfectly passive and inactive, that of the supplicant becomes awake and active. He must visualize the patient as the recipient of God's Blessing." This prayer should also last fifteen minutes.

"A prayer for help may be offered either in the presence or absence of the ailing and distressed . . . it is essential that the prayer in the absence of the ailing should be offered in the same manner and with the same devotion as a prayer offered in his presence . . . first visualize him as present . . . seated opposite . . . relaxed . . . have a clear impression of his appearance . . . having previously obtained knowledge of his abode, name, approximate age . . . general appearance . . . and if possible procure a likeness. The necessary part of the absent prayer is the identification of the one prayed for . . . mention name and location at outset of petition. It is best that the ailing one should be aware of the fact that some one is offering prayer for his restoration . . . more advantageous that he be informed of exact hour that prayer is to be offered and that during that period he

close his eyes and place himself in a state of perfect ease and relaxation . . . think of Divine Healing permeating him, restoring to perfect health."

"After each prayer", the author states, "definite changes for the better will take place in his condition; pain will become less intense each time, strength will supplant weakness, hope will replace despondency, and well-being will be regained."

NEW THOUGHT

As a matter of fact, the term New Thought covers the teachings of all the modern healing cults, including Christian Science, Jewish Science, and those still to be discussed. Moreover, the "thought" is as old as philosophy itself. Its modern advocates differ only in the manner in which their systems present it. As the systems become more highly organized, they tend to form separate cults and to work more or less independently, although many, if they qualify, become members in some such organization as the International New Thought Alliance or other centralizing agency. However, none of the other New Thought movements are as unified as Christian Science, a product of the same parent stem.

The entire movement in this country may be traced to the revival of transcendentalism which took place in New England in the early part of the nineteenth century. Contemporary thought at that time went through an upheaval under the influence of a keen interest in Neo-Platonism, with its attendant renewal of interest in mysticism, idealism, and particularly the idea of an immanent God.

In 1830 there was formed a rather loosely organized "Transcendental Movement", largely composed of the followers of such writers as Emerson, Channing, Ripley, Margaret Fuller, Brownson, and Hedge. Emerson's essay on the "Over Soul" gives the essence of this movement, a combination of the influences of the Orient and ancient Greece.

This has been passed on to New Thought, and to it has been added the influence of the so-called "New Psychology",[1] which

[1] This should not be confused with the term "New Psychology" as used in more scientific circles. It is doubtful whether the more popular form has any right to the name.

is differentiated from modern empiric psychology by its comparative lack of scientific method and its interest in transcendentalism, which the latter has left practically untouched.

Modern New Thought is also influenced by the doctrines of Theosophy concerning reincarnation, telepathy, and the like.

The fundamental principle underlying all New Thought ideas is that "there exists an infinite and eternal spiritual Principle of Being"[1] to which are attributed the qualities of "omnipotence, omniscience, omnipresence".

"This Principle of Being is regarded as Pure Spirit . . . the essence of Spirit being Mind. . . . The Principle of Being is spoken of as Universal Mind. Its substance is regarded as Mental Substance. Its power is regarded as Mental Power. From this arises the statement that 'All is Mind', including the manifestations, emanations or expressions of Mind."

Furthermore, "this principle of Being is held to be One and one only. There being nothing in existence other than this One Principle, the universe must be regarded as necessarily an emanation, manifestation, or expression of the One Principle of Being. There is nothing else for us to be. Moreover, the One Principle of Being must be immanent in everything, in different degrees of expression and manifestation."

Thus, if we are ill, unhappy, unsuccessful, it is because we are not manifesting this "Power Within", and it behooves us to take steps to put ourselves "in tune with the Infinite". This may be accomplished, according to some New Thought teachers, by simply relaxing, thus removing the inhibitions from the flow of energy stored in the mind. Others believe that the mind is influenced by the Infinite Mind and, by making it receptive, energy from without flows in to satisfy whatever need is present. Some compare the individual mind to a radio instrument. Its function is to receive energy radiating from the Divine Mind. Tuning in is a process of controlling the vibration rate of the receiving instrument that it may pick up the vibrations from the Infinite.

Practically all are agreed that the "subconscious mind" is either the storehouse of infinite energy or the instrument which must be manipulated in order that the individual may

[1] *History and Principles of New Thought*, by W. W. Atkinson. Holyoke, Mass.: Elizabeth Towne Publishing Company, 1915.

manifest the qualities of the Infinite Spirit of which he is but an emanation. Proceeding on this theory, innumerable methods of developing, stimulating, or releasing the forces of the subconscious mind, as well as methods of tuning in with the Infinite for one purpose or another, are proposed. Thus, we find teachers giving lectures followed by private courses and individual instruction in such things as "Concentration", "Relaxation", "How to Manifest", "How to Demonstrate", "Releasing the Forces of the Subconscious Mind", "How to Visualize", "How to Get Anything You Want", "How to Stop Worrying", and "How to Succeed".

Treatment varies with the school and may consist of relaxation with the realization of the desired end in mind; verbal treatment with New Thought principles, as expressed by various New Thought writers or passages from the Scriptures; meditation; visualization of the desired end, as recommended in the case of Jewish Science prayers; active or passive repetition with attention wholly concentrated on certain New Thought formulas, such as, in case one wishes to manifest health, "I am Well!" "I am Strong!" Prayer of the affirmative type also has an important place.

Music, rhythmic exercises, special types of voice culture, "vitalic" breathing, cultivation of one's special talents in order to express oneself better, all have their advocates, each professing to have a special influence over the latent powers that need only be released to emancipate the spirit of man. This is sought to the end that one may manifest more abundantly.

The New Thought student is thoroughly convinced of the influence of mind and he therefore "guards the portals" and, like the Christian Scientist, allows only constructive thoughts to enter. By exercising what he terms his will and imaging faculties, he believes that he can accomplish anything he desires to accomplish. The capacity is either within him, needing only to be released, or, if he believes that it comes from without, he feels that he need only place himself in the proper attitude of mind to receive it. The main point to him is that it is possible to him if he will but believe it, relax, and permit demonstration to take place.

Relaxation in the case of treatment may involve a compara-

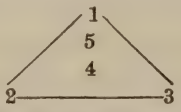
tively simple process, consisting of substituting a calm state of mind for a more active one and placing the body in a resting position, or it may advance through the numerous states of lowered tension, varying from mere resting to a condition suggestive at least of a deep auto-hypnosis.

There are some New Thought centers in which the teaching includes elements of mysticism. The mystics make a practice of entering the silence, communing with the "cosmic mind", and so forth. In this state, which is described by them as a "superconscious" rather than an "unconscious" or a "subconscious" state, the mystic seeks to draw near to the source of all power, and through his contact to become imbued with its qualities. He believes that it makes him more powerful, wiser, and less restricted by the limitations of time and space. In this state he has a "feeling of the presence" of God or the Infinite Power, and he returns to a conscious state with a sense of renewed energy which he believes he has gained from his contact with a higher consciousness than his own. In order to be worthy of this communion, he must live a holy life; and it is in respect to what constitutes this, as well as in the methods they advocate for "entering the silence", that teachers vary.

We have in New York an active Vedanta society, a Sufi center, teachers of the Yogi philosophy, and various modifications of these and other similar systems.

One of the methods of entering the silence for the realization of anything, including health, as taught by Premel el Adaras, president of the Society of Transcendent Science, is as follows:

Taking three candles, place them in the shape of a triangle thus:



Now take a crystal (each individual requires a special crystal, according to his date of birth) and place it at 4. Next place some incense (this also must be individual) at 5.

Have no other light except the candles and the glow of the burning incense. Sit with limbs folded as in the position indicated in likenesses of Buddha. Hold the arms rigidly flexed, forearms parallel with chest, hands outspread. Roll the tongue up and place it against the upper front teeth. Hold mouth shut, teeth one-eighth inch apart. This is to insure passing above the hypnotic into the "superconscious" state. Close the eyes. Now maintain this position until the hands are numb.

> Then look in the crystal and you will see yourself as you want to be, well, successful, happy, or whatever your desire may be. After repeating this process for seven nights, you will have tuned your mind in on Health, Wealth, Happiness, or whatever you desire. From thenceforth you need but relax and you will be attracted naturally to the desired end.

A variation of this treatment for health is to proceed with candles, crystal, and incense as directed above.

> Instead of squatting on the floor or before the table on which they are placed, lie down totally relaxed on your bed. Drone slowly and distinctly until you fall asleep, the words Om, Mane, Padme, Hum, Om, Oum, taking care to allow the "m" sound to resound and cause a buzzing sensation directly above the nose. This will remove all symptoms and the patient will awaken refreshed and quite well.

This procedure is extreme, and less radical New Thought teaching does not as a rule promulgate such methods. Relaxation, however, figures largely in all treatments, and the use of formulas to be repeated under concentrated attention is an important element. Curing disease also is an active part of the work.

Although they do not assume the authority of parting the patient from his physician, as do Christian Science practitioners, New Thought practitioners state that the patient is soon convinced of the greater efficacy of the new method and leaves his "crutches"—*i.e.*, medicine, eyeglasses if he wears them, and the like, behind. It becomes quite unnecessary for the New Thought student to consult a physician. He feels that doing so interferes with his progress in his ability to help himself, or to be helped by New Thought, because it raises doubt in his mind.

At the last annual convention of the International New Thought Alliance, 10,000 persons were present. It is not possible, however, to obtain a reliable estimate of the large number of people connected with the New Thought movement, because it is so widely scattered. It has centers of one kind and another throughout the world. Its literature is very extensive. Ralph Waldo Trine's book, *In Tune with the Infinite,* one of the best known New Thought books, has already been through 700 editions. The teachings are promulgated through magazines with wide circulation, lectures—apparently always well attended—private courses, and individual instruction. Treatments are given by practitioners who are as a rule also teach-

ers and lecturers. Meetings are for the most part held in hotel parlors or lecture halls. There are as yet no organized New Thought churches housed in church edifices of their own.

Prominent among New Thought writers are Ralph Waldo Trine, Elizabeth and William Towne, Charles G. Leland, H. Emilie Cady, Kate Boehme, George Warton James, Gertrude Bradford, and William Walker Atkinson, and there are others too numerous to mention. The literature includes almost every topic of successful living, with titles such as, *How to Remake Yourself; How to Cure Yourself; Lessons on Truth; You and Your Forces; Worry, Hurry Cured; Your Will Power, How to Develop It;* and *Health and Wealth from Within.*

DIVINE SCIENCE

Strictly speaking, while merely another type of New Thought, Divine Science stands out by itself. Its teaching is somewhat less complex, although there is a tendency for Divine healers to build up systems which are more or less individual and dependent on their personal convictions. The fundamental teachings are comparatively simple.

1. God is good and wishes only good for his creatures.
2. Disease, unhappiness, misfortune are of man's own making.
3. God will cure man and show him how to overcome all difficulties if man will but follow God, believing in his omniscience, omnipotence, and omnipresence.

Treatment of a sufferer consists in persuading the individual of these facts, especially of raising in him the belief that God will cure him if he asks him to do so. This may be accomplished through conversation or reading of appropriate Scripture passages. When faith has been firmly established, the patient's state of expectancy is further enhanced by earnest prayer of an affirmative nature. This is not attempted until relaxation has been accomplished, and until full coöperation on the part of the patient has been secured. Prayer is usually followed by "laying on of hands". This consists of placing the hands on the head of the patient.

To certain healers who believe themselves imbued with magnetic powers, this is a most important part of the treatment and must be carried out by a more or less elaborate technic

with regard to position of the hands and attitude of the healer, in order that the flow of power from healer to patient may be facilitated. Others ridicule this idea.

New York has seen many such Divine healers, notable among them Francis Schlatter, Bradley Newell, John Alexander Dowie, and more recently James Moore Hickson. The Middle West still has several settlements established by Dowie. In New York are three active centers carrying on the work founded about 1919 by the late John Murray.

The followers of Murray believe that the mind forms the patterns for conditions in the physical body, and they guard their thoughts accordingly. They try to follow the teachings of Christ as interpreted by the founder of Divine Science, as the movement is known. In this way, they learn to think rightly and their welfare is accordingly influenced. They believe that they can dispense with medical help.

Those who have followed Mr. Murray in the leadership of the movement continue to teach and to heal. Besides work with individuals, they carry on daily public healing services. These consist of a short address by the leader, including a discussion of some appropriate Bible text, prayer, and a "treatment". The leader reads or recites a given passage from the Scriptures or from Mr. Murray's writings, while the listeners close their eyes and relax. This is usually followed by affirmative prayer. The work is supported by free-will offerings and the sale of Mr. Murray's numerous writings. These meetings are well attended, and the movement has hundreds of loyal, enthusiastic followers. The mention of Murray's name in other New Thought audiences frequently brings out considerable applause.

The best known Divine healer at present in this country is probably Mrs. Amy McPherson, who conducts services of a revivalistic nature and also does individual work. She is reputed as unusually successful in bringing relief to all kinds of sufferers, and is so popular that her followers have recently erected a large temple for her in Los Angeles, at a cost of $100,000. Mrs. McPherson claims "cures" in 80 per cent of the cases she treats.

SCIENTIFIC CHRISTIANITY

Christianity to some is distinctly a healing movement. Applied Christianity, they believe, is capable of removing every difficulty in the world. Especially is it applicable to physical disease. Christ preached faith, and those who apply the Gospel teachings to the healing of the body lay stress on this mental state. They have developed systems by which the patient's mind becomes imbued with the idea that by communion with God he may be healed, and they also teach methods by which this communion may be effected. The material used to develop these ideas is taken from the Scriptures and from the writings of various New Thought authors. The system usually consists of daily reading along these lines, meditation on certain appropriate thoughts, relaxation, and affirmative prayer. Treatment consists of relaxation, reading or listening to an appropriate passage of Scripture, affirmation, or silent prayer.

The most highly organized movement of this nature is Unity, Scientific Christianity. Kansas City is the headquarters for this movement. It publishes a magazine called *Unity,* which has a circulation of about 185,000. This contains news of interest to the various centers, which are established throughout the country in the form of prayer groups, discussions of the teachings of the gospels as interpreted by the leaders of the movement, testimonials of results obtained by various members through the application of their principles, and other matter. Lecturers are sent out from headquarters to organize guilds in communities, and a prayer service is maintained at the larger centers. It is said that through its literature, lecturers, guilds, practitioners, and prayer service, the Unity Society reaches from three to five million people yearly.

The following testimonials, quoted from recent issues of *Unity,* indicate the type of response to the prayer service provided at the Kansas City headquarters:

HEALTH

Peoria, Ill.—I am thankful to you for the healing of my son. His arm was suddenly and completely healed. He did not know that I had written to you for help.—Mrs. W. C. H.

Cleveland, Ohio.—I wrote you asking that I might be healed of diabetes and gallstones. I am thankful to say that I have been healed.—Mrs. M. B.

Lorraine, Kan.—Our daughter has had an operation and the doctors said that she could not live. I asked Jesus to heal her, and I sent a telegram to *Unity*. She began to improve immediately. The doctor said that her recovery was a miracle. I thank God that she is alive and well to-day.—Mrs. W. E. B.

PROSPERITY

Kansas City, Mo.—I wrote you asking for prayers to assist me in renting vacant apartments. Each day I faithfully held the thought that you sent me and all the apartments now are filled.—A. L. M.

East Orange, N. J.—I have made a business connection which has promise far beyond any hopes that I entertained when I wrote you for prayers. May God bless you in your wonderful work.—C. F. B.

New York.—Wonderful things have happened since I wrote to you. I was then out of work. Now I am in my old position, and have had a raise in salary.—M. T.

MISCELLANEOUS

Hot Springs, Ark.—Find enclosed $50, my tithe. Your literature has helped me more than I can possibly express. There was a dreadful hailstorm here and my car happened to be sitting out in the front yard. Lumps of ice larger than a hen's egg fell thick and fast. I placed everything of mine in the Lord's hands. None of my property was damaged, while all around there were battered roofs, broken windows, and damaged cars. I did not forget to thank God for his protection.—Mrs. A. W. C.

Tithing is the method of reimbursement used. In a booklet published by the Unity Society entitled *Tithing,* an interesting history of this method is given from the time of its appearance in the Mosaic law. From the earliest times it has been the custom for those who observe tithing to give 10 per cent of their possessions to the Lord, and it is a matter of common belief that those who do this will prosper.

The eastern representative of the Unity Society is Mr. Richard Lynch. Mr. Lynch was himself an invalid for the greater part of his life until he discovered how to heal through applying the methods which he now teaches. He talks to large audiences almost daily. The topics of his lectures include such subjects as health, happiness, prosperity, character formation, and personality. Mr. Lynch also carries on some private practice in healing, and conducts services attended by an enthusiastic following on Sunday mornings. At the registered class lectures, Mr. Lynch's audience usually numbers from 300 to 500 people. He started in New York with only

six people, three years ago. There are ten registered practitioners connected with the New York headquarters, and an emergency prayer service is also maintained there. Followers of this school, after a short experience with the success of its methods, prefer them to those of medicine, and voluntarily dispense with the latter in order to strengthen their faith. But Unity practitioners, like all New Thought practitioners, do not demand that they do so, and do not withdraw their services if the patient wishes to consult a physician as well.

VARIOUS OTHER SIMILAR MOVEMENTS

New Thought and Christian Science are types of the same idea expressed in somewhat different ways, though by methods fundamentally similar, however different they may be in detail. Christian Science represents what is known as an "absolute" system, while most New Thought movements represent a comparatively "relative" system. There appear to be innumerable other systems more or less like the one or the other in that they are more "relative" or "absolute" in nature. They differ in their method of treatment, some treating "silently", some "audibly", some making their appeal through excitation, others through relaxation.

One of the most extensive movements using excitation and audible treatment is the Rawson school, founded by the late F. S. Rawson in 1919. His work is being carried on by more than a hundred practitioners in this country, who treat for success, happiness, and health by a system consisting of vehement negation of the undesirable and affirmation of the desired. By attuning his mind in this way, the individual is enabled to "manifest" and to "demonstrate". It is said by Rawson followers to be the highest system of thought, and they are enthusiastic in their declarations as to its practicability.

In the philosophy of Burnell, we have a system of absolute thought. The follower of this system of philosophy and thought meditates on such axioms as these:

> I know that I am because I cannot say I am not. Therefore Being or Is-ness, or Consciousness, or Self, must be Truth.
>
> Truth is that which Is, and as there cannot be that which is not, therefore that which is, or Truth, must be all there is.

The individual becomes conscious of truth, perfection, cosmic consciousness. His mind, comprehending perfection, reflects perfection; and, even as his mind, his body becomes perfect.

SPIRITUALISTS

The spiritualist movement has a firm hold in New York. There are said to be many smaller circles which meet in private homes and there are at least twenty comparatively well-organized societies whose services are advertised in the Sunday newspapers as open to the public. Attendance appears to vary from about fifteen to one hundred people, depending on circumstances. Healing is frequently a part of the services, and some of the church "pastors" give private consultations.

It is believed that sickness is due to demoniacal possession, and the purpose of the healing service is to drive out the evil spirit. This can be accomplished in various ways.

The individual himself may so conduct his life that the evil spirit will of its own accord depart, since all evil spirits succumb when faced in the name of Christ. Or a group of individuals, gathered to worship the greatest spirit, God, may thus invite beneficent spirits, who will overcome the evil spirit and cause him to depart.

Another method consists in availing oneself of the services of a medium, who, being guided by the spirits of certain departed ones who were authorities on this earth, goes into a trance during which he or she lends his or her body to these spirits that they may speak to the patient and advise him what to do.

Still another method is that used by Titus Bull, M.D., a colleague of the late Professor Hyslop, who believes that it is possible to demonstrate that certain types of insanity are due to the presence of evil spirits. Dr. Bull is using a medium in his practice. His method is to transfer the evil spirit from the patient to the medium and to educate it by persuasion. This is accomplished through long conversations, sometimes taking the form of serious debates. The doctor is guided in his work by the spirits of a group of famous scientists. He is thoroughly convinced that exorcising a demon results only in passing it on, and has therefore followed the educational

method in his practice, for by educating the evil spirit his influence for evil may be overcome once and for all.

Exorcising is a more common method. I witnessed a series of healing services at a certain Negro church in which this method was used amid considerable emotional demonstration. It consists of performing certain mesmeric passes in order to gain control over the spirit, and then commanding it to depart.

It is considered necessary for those who would be successful healers to live lives of great self-denial and saintliness in order that they may command evil spirits and that these spirits may have no power over them. The patient also must take heed to his morals in order that he may be completely cured and remain well. He must make himself an unsuitable host for an evil spirit.

If a person is sufficiently saintly, it is believed that evil spirits vanish at his approach, and he may effect instantaneous cures in some cases by merely touching the sufferer. Dr. Bull states that he is forced to make all sorts of sacrifices in order to maintain his power. He also states that he is able to cure certain conditions by placing his hands on the patient. However, he is using the medium and taking notes on the exact details of the procedure in most instances in order to perfect the method for the use of others who may wish to use it and to obtain recorded data on which he hopes to base proof of his contentions.

THEOSOPHY

Certain forms of Theosophy include healing in their services. The method may be that of the spiritualists or it may make use of telepathy. In the latter case, it is believed that the patient is helped by the concentration of the thought of all those present. Each attempts to realize health for him. The patient himself assumes a rather passive attitude and believes himself to be the recipient of power thus directed to him.

Neither Theosophy nor Spiritualism, however, deals with health primarily, nor are these societies definitely organized in any way for that express purpose. Nevertheless, many of their members believe that they are benefited through such healing services, and seek such help from their leader or

fellow members when they are ill. Compensation is on the basis of free-will offering, as a rule, although among the spiritualists there is a minimum charge of fifty cents in some cases.

RELIGIOUS HEALING BY INDIVIDUALS

This completes the discussion of organized movements independent of the church. There is yet to be considered the work of certain scattered individuals who are applying religion to the readjustment of unfortunates of one type or another who come to them for help. Some of these are individuals who believe that they have themselves been cured through faith. Many of them state that they were invalids or maladjusted in some way until religion became a unifying influence in their lives. Some have long medical histories, and not a few were definitely given up as incurable by their physicians.

By chance or through the influence of another they have succeeded in curing themselves. Their system consists of close study of the teachings of Jesus, an attempt to realize completely the import of his message, and an effort to live a truly Christian life, with all that it implies. With this realization comes a certain release from strain and a willingness to cast one's burdens on Jesus. Earnest prayer enters into the treatment of self or of others. Service for others, with its attendant joys, comes as a natural consequence of the deeper realization of truth. Prayer or relaxation accompanied by dwelling on certain ideas that tend to deepen the patient's faith and expectancy of relief act as "spiritual anæsthetics". Under its influence, pain and other symptoms are said to disappear.

Another type of individual work is that carried on by the Reverend Thomas Calvert.[1] Formerly a clergyman in a parish near Albany, he has for the last fifteen years been carrying on a church mission of healing in New York. Mr. Calvert places great faith in what he terms psychanalysis, in which he says he has instructed himself since its first appearance, and he uses it regularly to uncover his patients' "complexes". By persuasion and suggestion, he then proceeds to reëducate the individual, using religion as a basis for the readjustment.

[1] Mr. Calvert died in April, 1926.

When medical attention is required, the patient is referred to a physician. Mr. Calvert is entirely willing to work with physicians, and states that his work is not in any way designed to take the place of medical attention when this is needed. The mission is supported by donations and by the fees from patients. Originally, the plan of free-will offering was followed. It is still followed if the patient is not able to meet the fixed charge; but since a less systematic method of meeting expenses was found to threaten the support of the work, a definite price of $5 for forty-five minutes, $10 for ninety minutes, and $15 for 120 minutes has been set. Mr. Calvert alone carries on the treatment and devotes his entire time to the work. He has many testimonials to the success of his endeavors.

Still another method is that pursued by John D. Quackenbos, M.D., fellow of the Academy of Medicine and professor emeritus of Columbia University. He states that he has treated in the course of his practice more than 20,000 cases of addiction to alcohol, tobacco, or drugs. The method pursued by Dr. Quackenbos is to induce a subjective mental state through the administration of certain drugs, including trional, passion flower, and bromide. While the patient is in that state, he suggests the elimination of the pernicious habit. Dr. Quackenbos feels that when the patient is in the particular state which his medication induces, the operator has direct access to what may be the spirit, or some mental mechanism which is peculiarly susceptible to religious suggestion. He is brought to this conclusion because of the nature of the *rapport* established, the ready response on the part of the patient to influence for good, and the tendency to definite rejection of evil suggestions. For this reason he uses Biblical and other religious material in the suggestions which he introduces into the mind during his treatments. As a rule, these consume two hours.

Although he confines his practice mainly to the treatment of pernicious habits, he has also treated other conditions, and in cases of paralysis of one sort or another, for instance, where medicine is of little avail, he has witnessed, he believes, a marked improvement in control, securing in one treatment what it would ordinarily take weeks of reëducation in the

waking state to accomplish. So potent, says Dr. Quackenbos, is an idea introduced into the mind while in this condition, that even the effects of the comparatively large doses of the drugs appear to be entirely removed by post-hypnotic suggestion, and the patient experiences no difficulty in going about his regular pursuits as soon as he is brought back to consciousness.

Similar to the work of Dr. Quackenbos, but different in that the state of lowered psychologic tension may not be as profound and is brought about without drugs, is the work of certain other individuals outside the medical profession who, like the New Thought teachers, usually give public lectures, which they follow up with private courses and individual treatments. These individuals usually call themselves practical psychologists, or teachers of metaphysical healing.

SPECIAL APPLICATIONS OF RELIGION

Included in the testimony is the work of institutions where religion is made an essential element in the reconstruction of the lives of certain individuals.

The late William Gould, who founded Gould Farm, is said to have based his entire system on the healing power of religion. Mr. Gould believed that there is a definite technic by which the spirit may be developed, and with its development physical healing follows as a natural consequence. Religious discussions, prayer, and service for others enter essentially into the routine at Gould Farm. Since Mr. Gould's death, his co-workers feel that there has been a deepening of the spiritual life among them which has enabled them to carry on successfully in spite of Mr. Gould's physical absence.

Deaconess Young reports that her work with wayward girls is made possible by the influence of deep religious conviction in her own life, and uses religion as a stabilizing influence in the readjustment of those who come under her care.

The Salvation Army and other rescue societies provide testimony as to the influence of religion in the conversion of all sorts of derelicts, including the alcoholic and the drug addict.

OTHER ASPECTS OF THE SITUATION

Besides teachers and practitioners concerned in the organized movements and the individual work referred to in the preceding sections, there are many others in the field who reach the public through magazines and books, correspondence courses, phonograph records, and even radio talks.

Though we have made only a very cursory survey of the magazine field, our collection includes some twenty-five or thirty magazines with such titles as *Now, Truth, Leaves of Healing,* and the like. Brentano recently had a special display of books on this subject, containing works by a hundred or more authors.

One need but consult the advertisements in the Sunday newspapers to gather some idea of the activity going on every day. There are sometimes as many as twenty or twenty-five healing services or lectures on religious healing advertised among the notices of religious services in any one of the Saturday or Sunday issues of the newspapers. Advertisements in such publications as the *Psychology Magazine* shed further light on the extent and variety of the work.

In an attempt to obtain material in the way of advertisement dodgers, advertising lectures, and the like, I have collected enough to fill more than three large scrapbooks of fifty pages each, and this material merely begins to cover the field.

Modern Movements Within the Church

Jesus made healing a definite part of his ministry,[1] and in the Christian Church healing has been carried on more or less throughout its history. However, the attempt to introduce healing systems as a fundamental part of the Christian ministry is a comparatively recent development. There is now, however, a keen interest in this field and it is rapidly gaining ground. Especially in the Episcopal Church do we find a systematized effort to develop this work.

EPISCOPAL CHURCH

Emmanuel Movement.—The Emmanuel movement was established in the Emmanuel Church of Boston some twenty

[1] Tabulation of the miracles of Jesus is given by F. M. Witherill, in his *Healing in the Churches.* New York: Fleming H. Revell Company, 1925. P. 36.

years ago by Reverend Dr. Elwood Worcester and Reverend Dr. Samuel McComb. Neither had had medical training, but both were thoroughly grounded in psychology. The Emmanuel Church is still carrying on the work, and at one time it had associated with it men of high standing in the medical profession. Dr. Richard Cabot especially appears to have been interested in this work. When Mr. Worcester and Mr. McComb started their work, it was with a desire to do something for the physical relief as well as for the moral uplift of needy people who came within their reach. The work started with a tuberculosis class in which instruction was given to sufferers from that disease who lived in the tenements and who were unable to go away for treatment. They were given general health information and instruction on methods designed to help their condition and to prevent the spread of the disease to others.

The scope of the work was broadened by the addition of an "Emmanuel health class", in which treatment by suggestion was a feature. No person was admitted to the class without competent diagnosis of the case by a regular physician indicating that there was no organic disease demanding medical or surgical treatment and that the case was one amenable to treatment by psychic methods. Morning and evening clinics were held, and a weekly meeting. The daily treatments were given in the church. At the weekly meetings, the service consisted of Scripture reading, prayer, and a short address. Topics such as worry, anger, habit, suggestion, insomnia, nervousness, peace in the home, what the will can do, and what prayer can do were discussed. The work of the Emmanuel clinic is now largely confined to drug and alcohol addicts. Medical supervision is not now as well provided for as formerly.

Dr. Richard Cabot made a study of 178 cases treated at the Emmanuel clinic and reports as follows: In eighty-two cases of neurasthenia, seventeen patients were much improved, sixteen slightly improved, seventeen not at all improved, and in twenty results were not reported. Of twenty-two alcoholic addicts, eight were much improved. In other cases of fears, fixed ideas, obsessions, and hysteria, about one-fourth of the patients showed real improvement. There was also an encour-

aging success in the treatment of those addicted to the use of drugs, morphine, cocaine, and the like. Sad, discouraged, in some cases suicidal patients were helped and put in the way of living honorable and useful lives.

Nazarene Movement.—This movement was established by Reverend Henry Blauvelt Wilson of Boonton, New Jersey, in 1909. Mr. Wilson had formerly been priest in charge of Holy Cross Mission in the Ridgwood section of Brooklyn. In the course of his work he was frequently called on to comfort his parishioners and others in the hospital and in their homes when they were sick. He seemed to be particularly successful in accomplishing this and he felt that the Gospel message which he brought to them played an important rôle in the recovery of those whom he visited during their illnesses. On account of ill health on his own part he was forced to give up his work in the city and retire to a smaller parish out of town. This he did and shortly afterward he established the Society of the Nazarene on the following principles:

> The Society of the Nazarene, founded on the belief in our Lord's continued interest in the health of the body as well as the salvation of the soul: requirements for membership:
>
> 1. Belief in the divinity of Jesus Christ.
> 2. Belief in the possibility of following his precepts.
> 3. Belief in his works of healing and in the perpetuation of their power among believers by the use of the sacred name "Jesus of Nazareth".

The original membership was seven persons, all directly connected with Mr. Wilson's family. Mr. Wilson has since died and the work is being carried on by Reverend A. J. Gaynor Banks, with headquarters at the House of the Nazarene, Mountain Lakes, New Jersey. Membership in the society now numbers about 7,000. Its official organ, the *Healing Evangel,* has a circulation of about 6,000. At the Mountain Lakes headquarters is a "guest house where approved cases are received for special care and treatment under spiritual and medical supervision,[1] a chapel where daily services are held for intercession and healing, and a training school where leaders may

[1] There is a resident nurse on the guest-house staff, but no physician. Presumably medical cases are under the care of their own or local physicians. Plans for the future development of the work include more adequate provision for medical supervision.

receive proper instruction in the work of healing, develop such gifts as they may have, and receive spiritual instruction and encouragement".

Healing is accomplished through establishing faith that Christ still heals as he did when he was on earth, and that if his help is sought in the right way, it will be given. Certain healers are said to be endowed with a "gift" of healing. Some are born with it; others report having become aware of being in possession of it after some such experience as the disciples had on the day of Pentecost, after which their spiritual powers were markedly increased. Mr. Banks does not feel that he has been endowed with this gift of healing, but that he secures his results through the faith which he establishes in his patients. He believes that this state of consciousness results either in the removal of inhibitions to the natural healing forces or the stimulation of those forces, or that the body is thus conditioned to receive added strength from an infinite source. In individual cases he establishes faith through persuasion in personal conferences with the patient, teaching from those parts of the Gospel which deal with healing, and hetero-suggestion with Biblical material and affirmative prayer. He has also worked up a quantity of religious material for the patient to use after the method advised by Coué—that is, by systematic auto-suggestion before going to sleep, immediately on waking, and at intervals during the day.

The activities of the director of the Nazarene movement include missions, individual treatments, and intercessory prayer. A prayer service for others is held daily for those who ask for prayer to help them in any difficulty. The director includes in his prayers the names of all those who have communicated their need to him in person or by letter, telegraph, or other means.

Missions are held in various parts of the country by invitation from the clergy of the district. Previous to the coming of the missioner, the people are prepared through sermons to come to the mission expecting physical or spiritual help. The latter is considered as important as, if not more important than, the former; for although instantaneous or gradual physical cures are reported, it is believed that in the majority of cases the spiritual cure—that is, the enhancement of the pa-

tient's faith, desire to live a godly life, or ability to make the best of his handicaps if they cannot be removed—is the most important contribution of this work. It is stated that very often the patient's entire outlook on life is changed for the better, although his physical condition may remain the same.

A mission lasts for several days. Healing services and individual conferences are held daily. Any one who is ill or in trouble of any kind is welcomed and no one is excluded. No diagnosis in the case of physical conditions is required, nor has there been any systematized follow-up of the results. It is, however, definitely understood that the healing services are not intended to interfere with medical attention.

The services are similar to an ordinary church service, with sermon, hymns, and prayers designed to increase expectancy. Following the services, all those who wish to do so may go forward to receive the missioner's blessing, laying on of hands, and anointing with oil.

These missions are attended by hundreds, sometimes thousands, and by people suffering from all sorts of disease, as well as by those who attend merely for the spiritual uplift thus obtained. Interest in this type of service was greatly increased by the world-wide tour of the Divine healer Hickson, who has just completed a tour of the world under the auspices of the Episcopal Church, and Hickson's methods are being followed rather closely in the work of the Nazarene movement. As the healer anoints the petitioner, he addresses him in a positive manner, telling him that he will be healed, and that from henceforth he must obey God's laws, that he cannot expect to be healed and continue in godless ways, and that he shall repent and begin anew at once.

After the mission has been held in a community, a prayer guild is established there to continue with the work. The nucleus is made up of those whose interest has been kindled by the mission. Regular meetings are held at which prayers are said for the members and for others who may ask to be helped by the prayers. Such a prayer guild, probably the best established of its kind in New York, has been in existence for the last seven years in Grace Church. It is reported to have accomplished many seemingly miraculous cures as well as to

have justified its continuation through its influence on the general spiritual welfare of its members.

The work of the Nazarene movement is supported by membership dues, subscription to the monthly magazine, sale of other literature dealing with the work, free-will offerings for benefits received, and other voluntary contributions. Its purpose is not to take the place of other religious activity, but to make healing through faith a part of the work of the church. Nor is it designed to take the place of medicine, but to offer an aid to medicine. On the other hand, there is a tendency on the part of the leaders of the movement to believe that, with proper technic and development of the spiritual nature, more material methods may in time be superseded.

Church Mystical Union.—The purpose of this movement is to advance mysticism in the church. It attempts to cultivate the soul after the methods of the mystics. The movement is well established in England and is now gaining a following in this country. Reverend L. W. Fearn, warden of the Church Mystical Union, is at present engaged in the advancement of the movement in the United States. He holds services in certain churches, lectures on religious subjects, and gives private consultations.

Mr. Fearn states that in England he carries on work in cooperation with physicians, and says that he has been able to assist in the cure of many supposedly incurable conditions. He is loth to discuss this part of his work, however, since he believes it is only a corollary to his main purpose, which is to develop the spiritual nature. He believes that this can be accomplished by a definite technic, including righteous living and certain mystical influences. When the spiritual side of his nature is developed, the individual becomes conscious of latent power of which he was formerly quite unaware, and his entire attitude toward life is changed. "Superconsciousness", or "cosmic consciousness", with its attendant expansive influence, is the end in view.

Mr. Fearn states that he has so developed certain latent powers within himself that he is able to diagnose a patient's physical condition by placing his hands on him. He is also able to discern the relative degree of potential spirituality present in a given individual merely by being in his presence

for a short time. His treatment begins at the level at which he finds the patient, and is in accordance with the spiritual potentiality of the individual.

Individual Efforts: 1. *Group Treatment.*—Certain churches, since the time of Hickson's campaign, have continued to hold weekly healing services. Chief among them are St. Luke's, Trinity Chapel, Church of the Transfiguration, and St. Mary's Episcopal Church. The attendance at these services varies, and the leaders are inclined to believe that the group method should be replaced by more individualized work. In the healing service, prayer and laying on of hands preceded by a short sermon is the usual procedure.

2. (*a*) *Personal Treatment Primarily for Physical Healing.*—Certain clergymen who have been especially interested in the subject of healing have developed a technic for individual work. This consists for the most part in allowing the patient to talk about his difficulties, convincing him of Christ's power to heal, prayer, and in some cases laying on of hands. If the case is carried over a long period of time, instruction along the lines of Christian living is given. Reverend William T. Walsh of St. Luke's Church, who has perhaps given more thought to this subject than any one else not exclusively engaged in the practice of healing, states that there is in the Bible abundant evidence of a very definite technic of healing used by Jesus and his disciples. His forthcoming book[1] will discuss this subject.

"In dealing with the individual patient", says Mr. Walsh, "the best results are obtained when the patient is in a subjective state. When a subjective state has been brought about, emphatic, positive suggestion must be given."

It is necessary for the one giving the treatment "to be quietly, but deeply aware that life in him and life in the patient are one manifestation of the ultimate reality in the universe—namely, spirit." By spirit Mr. Walsh means "a reality which is not material, such as life". "When a person is sick, something has gone wrong with the 'life'." He believes that it is just as possible to transfuse this "non-material reality" as it is to transfuse a "material reality" like blood. The technic

[1] *Scientific Spiritual Healing*, by W. T. Walsh. New York: D. Appleton and Company.

by which the one is accomplished must be just as carefully developed as the other.

Mr. Walsh describes a healing treatment as follows:

SPIRITUAL HEALING IN THE CRISIS OF A DISEASE

A lawyer was stricken by a severe attack of pneumonia. In due course came the crisis, and while it was pending, his wife sent for me.

On arriving at their home, I asked, "What does the physician say?" The answer showed that it was a typical case. The physician had said that the crisis might come any time within the next twenty-four hours, and that while he hoped for the best, the balance might turn this way or that and no one could tell which way it would be. Everything depended now on his courage and his fighting spirit.

When I was shown to the patient's room, I found him very weak and only partly conscious; at least, so it seemed; but I found out from him later that he was conscious, but so weak that he could not give evidence of it. I sat on the bed beside him and gently stroked his forehead. He was restless, so I began to meditate aloud somewhat as follows:

"God says, 'Be still and know that I am God.' Look at me and when I tell you to close your eyes, they will close and a feeling of comfort and ease and peace will come about them. To be still means to relax. Now the muscles about your eyes relax and your eyelids close and already there is a feeling of ease and comfort and peace around your eyes.

"That feeling of ease and comfort and peace and well-being is going to spread all over the body. Now the muscles of your face and neck relax, and your head sinks easily and comfortably on the pillow."

Here I passed my hands over his chest, gently touching him as I continued: "Now the muscles about the chest relax and there is a feeling of ease and comfort and well-being all about your chest and around your back.

"There is such ease that you are not conscious of any effort in breathing. [The patient had been breathing with some difficulty when I arrived, but this gradually subsided.] The air is all about you and gently enters your lungs so smoothly and peacefully that it is now a pleasure to breathe.

"God speaks to your mind and says, 'Be still, mind, and know I am God.' So now your mind relaxes and is still. To relax means to let go. Your mind lets go of the past. Any doubts or fears that might in any wise interfere with the well-being of your body now depart. Your mind is still. It lets go of them and they are gone. Anything that you have heard or thought about your condition that might interfere with your peace or health likewise departs. There is nothing in the past to worry you. On the contrary, out of the past come only words of cheer and confidence, absolute confidence."

Continuing the treatment, I said: "Now your mind lets go of any thought about the future that might in any wise interfere with your well-being. There is nothing to fear in the future, for it stretches out before you like a pleasant way and you pass through it confidently, easily, and securely. Your mind is now entirely relaxed. It makes no effort. Without any effort you are going to hear and understand everything I say and no other sound will disturb you.

"God speaks now to the very soul of you, and says, 'Be still and know.' The Scripture says we are partakers of the divine nature. We partake of the life of God. God is the infinite life in all the world. He shares that life with you. God's life is immortal and you are immortal because you partake of the immortal life of God.

"God is the infinite power in all the world. You partake of that power. Deep within you, beneath body and mind, is the life which comes from God. It brings with it the power of God. You partake of his strength. Now the divine power manifests itself in the depths of your nature. It communicates itself to your heart, and your heart beats easily, smoothly, regularly, and irresistibly. Your heart feels such power that it knows that nothing can stop it, for the power of God manifests itself there.

"God is infinite vitality. You partake of that divine vitality. God shares it with you. It communicates itself to your heart, and your heart beats with its power. The divine vitality communicates itself to your blood. And now as the blood flows through your body the divine vitality is manifested in every cell and tissue and organ of your body. It takes away all feeling of congestion. It manifests itself in and through your lungs, relieving and strengthening. Every cell and tissue is now conscious of power and vitality and health and well-being from the infinite source.

"God is all courage. There is no fear in God. He shares that courage with you. You are partaking of courage from the infinite source of all courage. Your heart beats courageously. The blood flows along, bringing the message of courage to every cell and organ. Gladly they receive it. Courageously they do their work of eliminating and upbuilding. You are surrounded by courage as by the air you breathe, for in the divine courage, in God, we live and move and have our being.

"Even while you sleep you will be breathing in, as it were, life, power, vitality, courage, health and strength and peace. When you awake, you will be quite renewed." I then laid my hands on his head and chest, repeating the words of the Scripture, "They that believe shall lay hands on the sick and they shall be healed", and the following prayers: "Almighty Father, according to thy word we lay hands on this, thy servant. May he even at this time be conscious of thy power manifesting itself to the healing of his body, mind and soul. 'Now unto Him that is able to do exceeding abundantly above that we can ask or think, according to the power that worketh within us, unto him be glory in the church by Christ Jesus throughout all ages, world without end. Amen.'" [Ephesians 3:21.]

The next day I was informed that after I left the sick man he had his first real rest in some days. I continued to treat him daily for about a week, and in due time he was quite restored to health. Toward the end of the time I treated him, he said, "I have a wonderful physician, but I know who saved my life. When you first came to me, I felt that I was gradually slipping away. I was too weak and tired to resist. But as you treated me I experienced what you were describing. You brought just what I needed and at the time when I needed it most."

Mr. Walsh places great emphasis on the establishment of expectancy on the part of the patient, and belief that the

"healer" can help him. He makes a plea for establishing faith which is based on truth rather than making a practice of taking advantage of imperfect beliefs for temporary gain in the form of curing disease. The ultimate aim of spiritual healing, he says, "includes teaching the patient the whole truth as far as we understand it and he can receive it". He also makes a plea for common sense and the use of medicine so far as this is called for in every case.

(*b*) *Personal Treatment with Physical Healing as a Secondary Matter.*—Certain clergymen who have not taken up religious healing as an end in itself report cases from their experience in carrying out the pastoral duties of their office, which would bear witness to the therapeutic value of faith. Professor Batten of General Theological Seminary, who now gives instruction in religious therapeutics at that institution, has had a varied experience along these lines. In the course of his ministry it was not unusual for people who were seriously ill or who had been given up by their physicians to come to him and ask for spiritual help in their distress. Through the calming influence of the religious faith which he was able to build up in them, patients were frequently restored to confidence and enabled to make the most of their remaining days, if not helped to unexpected recovery.

Professor Batten places more confidence in an individual approach, depending on the nature of each particular problem, than on more wholesale methods, and regards physical restoration as secondary to the establishment of spiritual health with its stabilizing influence. This view is held by many who fear that placing emphasis on physical healing will have a deleterious effect on religion.

Body and Soul Clinic.—This clinic was started by Dr. Edward Cowles at St. Marks In-The-Bouwerie about three years ago. It meets in St. Mark's Church three times a week. Certain patients receive additional treatments on non-clinic days at the Park Avenue Hospital, where Dr. Cowles also sees private patients. The work in this clinic is carried on by Dr. Cowles, as chief and examining physician, a clergyman, and several volunteer assistants, some of whom are former patients. The doctor talks with each patient and makes such limited physical examinations as the clinic facilities and time

permit. Certain laboratory tests are done at a private laboratory to assist in the diagnosis and plan of treatment. When more careful examination is called for by the nature of the case, the director states, patients are referred to other clinics where such examinations may be made.

Treatment at the clinic consists of suggestion administered individually by Dr. Cowles, followed by religious suggestion administered to groups by the clergyman. Immediately preceding the treatment, patients are given a sedative. As he administers suggestion, the doctor presses the closed eyes of the patient, using the fingers of one hand, and with his other hand takes hold of the patient's arm. During this treatment, which consumes only a few moments, the patients lie down in turn on couches provided for the purpose. Nervous and mental diseases seem to predominate. The clinic usually ministers to about seventy-five people at a session, mainly young men and women. Patients who have been helped are enthusiastic in their claims of cure and take pleasure in testifying to the efficacy of the treatment, some speaking of it as magic and quite superior to anything they have ever experienced elsewhere. They volunteer this information and recite their testimony in the manner of an oft repeated routine performance. The services of the clinic are free. There is a nominal charge for laboratory examinations when the patient is able to pay for them.

OTHER PROTESTANT CHURCHES

Healing has not been taken up in a systematic way in other Protestant churches, but the interest in it is keen. Many churches have opened their doors to various teachers of the New Thought school. The work takes the form of a series of free public lectures, supported by free-will offerings and followed by private courses, which usually cost about $25 for a series of six or eight lectures. Private consultations are also a feature. Other churches have held evangelistic services during the visits of various divine healers to this city. Some physicians report that clergymen have helped them materially in the treatment of particular types of patients. Physicians also enlist the clergyman's aid in the hospitals and in the

home when it is felt that his influence will help to raise a patient's morale, as it frequently does with certain types.

Guild of Health.—This organization is of comparatively recent development along lines similar to those of the Nazarene movement, in that it seeks to establish prayer guilds in churches. The Guild of Health, however, confines its work to Protestant churches other than the Episcopal, and emphasizes the educational rather than the ceremonial approach. Reverend Franklyn Cole Sherman, formerly rector of St. Paul's Church in Akron, Ohio, is the founder. The headquarters are in Cleveland. Since its foundation three years ago, it has twice been necessary for the guild to move to larger quarters. Its work is carried on through lectures, literature, and personal service on the part of Mr. Sherman. The purposes of the work as stated by Mr. Sherman are:

1. To present a Christian philosophy of life, in harmony with modern philosophy and psychology.
2. To show how the Christian religion can be made practical in the daily life. Special attention is given to problems of mental and physical health.
3. To demonstrate the practical methods that have been found effective, the technic of faith and prayer.

Mr. Sherman is an enthusiast with regard to spiritual healing. He believes that he was himself cured of tuberculosis thereby, and that, if proper technic is developed, all diseases, both functional and organic, may be attacked by this method. Cures, declares Mr. Sherman, are effected by coming into direct conscious communion with God. Although Mr. Sherman feels that in time medical attention will be superfluous, he most firmly expresses the opinion that, until a superior method is developed, physicians and clergymen must and should work hand in hand.

The work of the guild is carried on by donations, membership dues, subscriptions to its official organ—a monthly magazine called *Applied Religion*—and free-will offerings.

CATHOLIC CHURCHES

Healing has always occupied considerable attention in the Roman Catholic Church. Many Catholic churches possess relics which are believed to have special healing powers. This may be a piece of bone taken from the body of a saint, as a

rule one who is said to have performed miracles of healing during his or her lifetime. The believer may at any time offer prayers to this saint or ask the priest to apply the relic. This is done by touching the afflicted part of the body with the relic (enclosed in a case) and it is believed that healing may thus be accelerated. Some churches hold weekly healing services which are attended by all denominations in great numbers. The particular relics at these churches are believed to have special healing power. It is distinctly understood, however, that the patient should also have medical attention when this should be sought.

Some priests carry a portable relic on their visits to the sick. Many report noticeable improvement following its application. The prayers for the sick offered both at the bedside and in the church are believed to have a direct influence on the patient's welfare, and not infrequently marked improvement occurs after the priest has administered unction.

Another healing ceremony observed in the Catholic Church is the novena. This consists of visits to seek help by means of touching a relic once a week for nine consecutive weeks, or daily for nine consecutive days. Following each service the patient is touched with the relic. During the nine weeks or days, he is expected to live an especially devout life and to devote considerable time to meditation and prayer.

Still another and perhaps the most important type of healing in connection with the Roman Catholic Church is that accomplished at various shrines. There is, as a rule, some legend connected with the shrine which leads the pilgrim to believe that if he makes a pilgrimage to that particular spot and offers a petition for help, he will be instantaneously healed. The devout Catholic is convinced that these cures, when they occur, as they sometimes do, are miracles accomplished through direct answer to his prayer.

Lourdes in France and St. Anne de Beaupré in Canada are the most famous Catholic shrines. The legend connected with Lourdes is that the Blessed Virgin appeared to a peasant girl in that place and told her that there was a spring in the grotto at her feet which would effect the cure of the physical ills of those who would bathe therein. And it is claimed that what the Virgin said is true. The spring was first established in

1888. From that time on pilgrims have gone to Lourdes in great numbers, figures affirming the number to be about 1,000,000 a year now, some for relief from physical ills, some merely for spiritual uplift, some out of mere curiosity. Though comparatively few are healed, it is estimated that since the discovery of the healing power of this pool of water 4,000 in all have experienced cures. In the chapel at the shrine are crutches and other supports that have been thrown aside by the healed who had no further use for them.

A medical board is maintained at the shrine and every cure is certified by this board. A patient must bring with him from his personal physician documentary evidence of his condition before seeking the cure. It is said that only those patients who bring evidence of having suffered from organic disease are classified as miraculously healed. The *Journal de la Grotte* reports each case in detail, and any visiting physician who desires to examine any patient when a cure is reported is privileged to do so.

The procedure at Lourdes is very complex. A long series of preparatory ceremonials and devotions precedes the actual dipping in the pool.

SPECIAL ACTIVITIES IN CHURCHES

Aside from any connection with guilds or organized prayer circles and the like, many churches have well-established health work similar to that in any other field of social service, carried on through medical clinic, visiting nurse, social case-worker, or other individual agent.

Churches also support convalescent homes, preventoriums, and hospitals. They have an interest in various auxiliaries in connection with all sorts of medical work. The Episcopal Church, for instance, supports the City Mission Society, which, among its other activities, has visiting or resident chaplains in forty New York hospitals. Because they are so pressed for time, the work of these men is confined almost entirely to the giving of extreme unction and the services to patients about to undergo surgical operations.

The church has an unusual opportunity to reach a great number of people in its various activities. Few recognize

the influence that a large modern church may have in a community. It is estimated that 55,500 people used the Madison Avenue Presbyterian Church House for social and educational activities during the past year. Moreover, 39,161 attended Sunday school, 475 of the enrolled members of which are over eighteen years of age. Besides this, 58,000 persons attended public worship on Sundays. The pews are free, and all are welcome. During the year the ministers and other members of the staff made 9,699 visits among members of the congregation. This is mentioned in passing merely to indicate the possibilities of such an organization as a means of spreading knowledge and influencing behavior.

PROBLEM RECOGNIZED BY IMPORTANT CHURCH AGENCIES

Leaders in theological seminaries are interested in this problem because they must educate ministers in the right attitude toward it. For the most part they have taken no definite stand in the matter because its growth has come on them unaware. In general, as expressed by Professor Elliott of Union Theological Seminary, the theologian is not desirous of making religion a healing movement. He does not wish to take up work which the psychotherapist is better able to handle. On the other hand, he wishes to do his part if called on to do so, and especially does he wish to make religion an integral part of every aspect of life, that its unifying influence may work for the betterment of man at all times and that it may lend support especially in time of distress.

As a central agency, including in its membership many different denominations and churches throughout the country, the Federal Council of Churches of Christ in America is continually called on to give advice or to express opinions with regard to all aspects of church work. With the present interest in healing and comparatively little knowledge of it on which to base reliable opinions, it has become a practical necessity for this body to undertake research with regard to it. One of the problems before its research department at the present moment is the relation of religion and health. It is withholding opinion until such research shall have been completed.

PSYCHOLOGIC FACTORS

As we review the methods employed in the types of religious therapy which I have been considering, we are immediately impressed with the rôle allotted to suggestion.

Each system in some way introduces the idea of cure or health after preparing the mind through one means or another to accept it, and the fundamental principle of each system is the assumption that any idea possessing the mind tends to materialize in the body.

This is, indeed, a fundamental law in suggestion; but, happily or unhappily, there are numerous ways in which this tendency may be neutralized long before it actually does materialize in the body. Inhibitory influences both in the mind and in the body must be taken into account.

Now, counteracting ideas are among the most powerful inhibitors. Recognizing this, the faith healer makes his first step the overcoming of whatever inhibiting ideas may be present in the patient's mind. Not until this is accomplished does he advance the suggestion designed to serve his especial purpose.

His method may be a process by which he builds up a system of ideas through discussion, reading, recitation, meditation, concentration, "treatment", or other method of filling the patient's mind with his particular line of thought. By constant repetition alone these ideas may gain precedence over other ideas which he constantly denies or associates in a negative way with the patient's desire—to get well, to be prosperous, to be happy. The new system soon becomes dynamic. Being linked with the patient's desire and attached by a religious setting to an instinctive mechanism, it readily gains possession of the field. Constant consideration of it establishes the ideas involved, just as any other habit becomes established. As long as the patient keeps in practice, it is quite as difficult for him to change his mental attitude as it would be for him to change a motor habit once firmly established.

Thus, in the case of the trained Christian Scientist and other New Thought students, the suggestion that enters into the treatment falls in especially prepared soil. The critical

faculties are as effectively controlled as if the patient were hypnotized. One link in the chain of conditions that may inhibit the materialization of the idea in bodily activity is eliminated. Then, too, there is the matter of physical relaxation and the further concentration of attention involved in the conditions under which treatment is given. Even though the proper apperceptive mass has not been built up, the patient's mind would naturally be less resistive under these conditions of control.

In some cases the descriptions given by patients who have undergone treatment at the hands of certain practitioners closely resemble the description of what Braid terms slight hypnosis: "The subjects become more or less lethargic, but are conscious of what takes place and suffer no subsequent loss of memory." In some of Braid's experiments, this group comprised about 90 per cent of those who responded to curative suggestions.

Cramping the attention in one way or another is an effective method of producing hypnosis. While the members of these healing cults volubly deny that their work in any way involves hypnotism, they could not fail to note the resemblance were they aware of the facts in the case. Few recognize that there are all stages of subjectivity in hypnotism, and that a person may become as effectively controlled by an idea that has taken full possession of his mind as he may be by the operator in what he readily recognizes as hypnosis.

And so it is with other forms of "treatment". The Divine healer, for instance, prepares the way for his final suggestion by a preparatory discourse and affirmative prayer. He withholds the delivery of his dynamic suggestion until something conveyed to him through his *rapport* with the patient tells him that the psychologic moment has arrived. The patient at this time may be experiencing such intense emotion, as the result of the implicit faith that has been established in his mind, with its resultant expectancy, that he may be completely incapacitated from exercising his critical faculties. It may be that he is in some other state of subjectivity, probably hypnotic; or, if he has come for the relief of some acute distress, such as extreme pain, his attention may be so completely absorbed by his symptoms that he can offer no resistance to

the idea now implanted in his mind by the operator. The principle is the same in all cases. Ideas that may counteract the situation are first controlled, and the patient's suggestibility is then further enhanced by the conditions of the treatment.

A similar situation prevails in cases in which cures are effected through relics or devotions at shrines. The long series of preliminary ceremonies establish expectancy, and the final act is consummated at a moment when emotion is at its height or when the patient is otherwise unable to oppose the suggestion.

But there are certain aspects of the situation, especially in the case of the more elaborately organized systems, not so readily discernible on the surface. To appreciate these, we must consider how his experience or how his attention to a system of ideas influences the subject's affective life.

Conveyed to the patient in one way or another are certain fundamental ideas which become so firmly implanted in his mind that they furnish him with convictions beyond all dispute which have a marked emotional effect. These ideas form the nucleus for the belief that God, an all-powerful, all-knowing, everywhere present beneficent power or force, actually exists; that this power exists in a given relationship to the individual; that the establishment of such a relationship is natural and normal; that such a relationship, once established, enables him to commune with this power; that in this communion a contact is formed which results in a flow of energy which can produce effects not otherwise attainable.

It is in spite of the shortcomings of some systems, even of recognized theology or institutionalized religion, that this development of what we may term personal religion may take place. The personality of the individual, his other religious experiences, his mental attitude, and his life in general, are undoubtedly deciding factors; but stimulus is supplied by the system or the experience through which the fundamental ideas are introduced.

The more earnest followers of any of the typical religious therapeutic cults are unanimous in their declaration that they have been led to a fuller realization of life, and that when they first fully comprehended the meaning of the idea of God involved in the teaching of their leader, everything changed for

them. They speak of having developed on the basis of this an indescribable joy and satisfaction, a sense of security not otherwise attainable, and an ability to face life with unbounded courage. The full import of these ideas may burst on the patient in the form of sudden enlightenment as the result of some vital experience that serves to integrate his previous experience, or it may be built up by a more gradual process. Regardless of how he comes into a full realization of their significance, this realization has a distinct influence on his affective life.

The appeal to the ego is tremendous. What could have a more expansive influence on the personality than to believe, without the slightest shadow of doubt, that one is essential to the plans of God himself, that one partakes of the qualities of God? Followed to its logical conclusion with regard to disease, if God is omnipotent and man partakes of his qualities, indeed, if God is in man, disease is a very minor matter and can readily be overcome through this power within. And what could be more comforting than to know beyond the possibility of any doubt that one may turn at will to a higher power with absolute assurance that one will be given strength to meet any difficulty that may arise? Those who have attained this belief actually report a sense of security beyond their ability to account for otherwise, and those who have learned to carry on what they term effective communion with whatever power it may be that they recognize actually do report a restoration and a rejuvenation as a result of this communion.

The attainment of these convictions is reported to add new zest to life, to develop confidence, serenity of mind, cheerfulness, and a preponderance of loving affections toward others. Unfortunately, in some cases the latter is not followed to its logical conclusion, and it is entirely just to say that many of the cults fall short in this respect, appearing entirely selfish in their purpose. But even though optimism and cheerfulness are induced in the patient on a more superficial basis, it serves its purpose by raising his morale and directing his attitude toward the difficulties of life.

Particular mental states inherent in the functioning of the religious instinct may be of especial importance in their influ-

ence on physical conditions. Dr. William Brown Wilde, reader in mental philosophy in the University of Oxford, is sponsor for the statement, "We can say as a fact that suggestion produces results; that auto-suggestion produces more permanent results; and that if genuine faith is aroused, the most astounding results of a permanent nature may be produced."

William James, in discussing prayer, writes: "As regards prayer for the sick, if any medical fact can be considered to stand firm, it is that in certain environments prayer may contribute to recovery and should be encouraged as a therapeutic measure." He goes into considerable detail to make clear the nature of the mental process involved in prayer:

> "Man can learn to transcend those limitations (of finite thought) and draw wisdom and power at will . . . The divine presence is known through experience. The turning to a higher plane is a distinct act of consciousness. It is not a vague twilight or semiconscious experience. It is not an ecstasy, it is not a trance. It is not superconsciousness in the Vedantic sense. It is not due to self-hypnotism. It is a perfectly calm, sane, sound, rational, common-sense shifting of consciousness from phenomena of sense perception to phenomena of seership, from the thought of self to a distinctly higher realm. . . . For example, if the lower self be nervous, anxious, tense, one can in a few moments compel it to be calm. This is not done by a word simply. Again I say it is not hypnotism. It is by the exercise of power. One feels that spirit of peace as definitely as heat is perceived on a hot summer day. The power can be as surely used as the sun's rays can be focused and made to work, to set fire to wood."

It may well be that religious healing makes use of forces not ordinarily recognized. It remains for us to study the nature of these forces, to determine how far they are present in the normal person, how far they may be applied with sanity, and what method of application is most advantageous.

Scope and Evaluation of the Work

Now, we may ask, What limits do the advocates of the so-called faith cures place on the possibilities of their work? Except as indicated in the case of the more conservative in the theological field, the answer is, theoretically none. In the absence of proper records, we can judge only by verbal testimony, such records in the form of narrative as one hears on every side, and the few attempts that have been made at a

systematic study. In the course of this limited survey, we have heard and read endless testimony on the part of persons who believe that they have been cured of everything from a pain in the heel to cancer. Unbounded health, wealth, and happiness may be secured by those methods, according to some who have tried them. Results may be instantaneous, gradual, complete, or partial.

Certain New Thought advertisements, reproduced below, give an idea of what New Thought proposes to accomplish:

Financial Problems Solved Through New Thought; Rheumatism, Hay-Fever, and Business Difficulties Overcome; How New Thought Helped When My Husband Became a Flirt; How Constructive Thinking Helped Heal Tuberculosis; Replenishing the Nerve Centers; How to Heal Your Body and Pocketbook Through Expanding Consciousness; How to Be a Genius; Curing Epilepsy in Fifteen Minutes.

The psychologist, Henry H. Goddard, reports one of the most systematic studies that has been made on this subject.[1] Goddard included in his study more than 1,600 records of individual cures, mainly taken from the Divine healer Dowie's work. About two-thirds of these were females, and they ranged in age from six to eighty-six years. The greatest number ranged from twenty to fifty years, and among women the married were about three times as numerous as the unmarried. Further results of Dr. Goddard's study were as follows:

> "The duration of the disease from which they were healed varies from a few months to fifty-two years. The average time is about twelve years for each sex. Thirty-three per cent report instantaneous cures, 50 per cent gradual, and 17 per cent reported that they were not yet perfectly healed. It must be noted that while 33 per cent report instantaneous healing, it is clear from their own account that they almost always mean that pain ceased instantly. And it may be mentioned that of all the returns that give data on that point, almost every one shows that pain ceased at the time of prayer.
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> "Again, of the whole number, 76 per cent were treated or prayed with by Dr. Dowie in person; 7.5 per cent were prayed for by him at a distance; 4.5 per cent were prayed for by Mrs. Dowie; 7.5 per cent were healed in answer to their own prayers or efforts; and 4.5 per cent were healed in answer to prayers of friends.

[1] "The Effects of Mind on Body as Evidenced in Faith Cures", by H. H. Goddard. *American Journal of Psychology*, Vol. 10, pp. 431–502, April, 1899.

"The number of ailments mentioned in their accounts of themselves varies from one to nine for the males and one to eleven for the females.

"The time that had elapsed (at the time the study was made) since the cures varied from a few days to fourteen years. Time required for full recovery may be as much as two months. If longer than that, it seems to be regarded as a failure and is not mentioned."

Goddard's Classification of Diseases Cured *

	Nervous	Circulatory	Respiratory	Digestive	Contagious	Wounds	Cancer	Rheumatism
Males.....	20	10	20	15	5	14	5	11
Females.....	22	14.5	18	16	5	3.5	11.5	9.5

* The figures are in per cents.

"Among the remarkable features mentioned may be noted: Legs lengthened from 1 to 5 inches; 'gained 95 pounds'; hip 2½ inches reduced; fifty-six abscesses cured at one time; deaf and dumb; senseless three weeks; 'forty whiskies a day' cure; 'wreck physically'; hip disease; goiter; three bullets; fever settled in bones; appendicitis; leg shortened 2 inches; born blind."

"The following list of troubles, as stated by the patients themselves, is given:

"Abscess; accident; ague; appendicitis; ankle sprained; asthma; backache; back weak; bad habits; bilious trouble; blindness; blind from birth; blood poisoning; Bright's disease; bronchitis; bronchial disease; broken arm; burns; burned hands; blood disease; brain fever; cancer; cancer in tongue; cancerous tumor; carbuncle; catarrh; chills; cholera infantum; cholera morbus; congestion of lungs; consumption; constipation; convulsions; cough; chlorosis; compound curvature of the spine; croup; deafness; deaf and dumb; diabetes; diarrhea; diphtheria; dislocated shoulder; dislocated knee; dropsy; dysentery; dyspepsia; diphtheritic paralysis; devil cast out; earache; eczema; epilepsy; erysipelas; eyes, inflammation of; eyes, weak; eyes, sight failing; feebleminded child; fever; fever sores; felon; fistula; gangrene; gambling; goiter; granulated eyelids; gallstones; headache; healed when dying; heart disease; heart broken; heel lame; hay-fever; hydatids; hydrophobia; hemorrhage of lungs; hemorrhage of kidneys; hemorrhoids; hernia; hip broken; hip disease; hip joint renewed; hysteria; imperfect sight; infidelity; impediment in speech; impotent; indigestion; inflammation of bowels; inflammation of stomach; inflammation of lungs; inflammatory rheumatism; internal tumor; ivy poison; internal troubles; intestinal trouble; insanity; kidney and bladder; knee, injured; knee, stiff; knee, swelling in; la grippe; lame, leg too long; leg too short; leg poisoned; leukemia; liver trouble; locomotor ataxia; lung trouble; lung fever; lumbago; malaria; measles; meningitis; morphine habit; mumps; nearsightedness; nervous exhaustion; nervous prostration; nervous trouble; neuralgia; nervous debility; ovarian tumor; palsy; paralysis; periostitis; piles; pneumonia; polypus; puerpal convulsions; peritonitis; pleurisy; paralysis of bowels; palpitations of heart; quinsy; rheumatism; running sore; rib broken; rupture; salt rheum; scalding; scarlet fever; scrofula;

skin eruption; skull fracture; sick headache; spasms; seasickness; sleeplessness; smallpox; spinal meningitis; sore throat; spinal disease; spine, curvature of; sciatica; stone cancer; stigmatism; stiff hip joint; stomach trouble; sunstroke; synovitis; symmetrical keratiases of the palms and soles; tapeworm; throat trouble; tobacco; toothache; tonsillitis; tuberculosis; telegraphers' paralysis; tuberculosis of bowels; tumor; tumor, fibroid; thigh bone diseased; typhoid fever; ulcers; urinary trouble; ulcers in bowels; varicose ulcer; varicose veins; whisky; wounds; wrist sprained; weak lungs; weak eyes; white diphtheria; wild hairs; whooping cough; yellow fever."

Similar lists might be prepared from the records of cures ascribed to any one of these systems. We would also find cases of the same nature in which cures failed to be effected. But our research under the present circumstances would do us little good as far as obtaining any real knowledge with regard to the validity of the claims is concerned. This is due to the fact that none of these workers keep adequate records. They depend largely on the patients' testimony for diagnosis as well as for evidence of cure. With no control to determine how many patients were actually suffering from the conditions reported or how many of the reported cures were spontaneous or due to other influences than the mental treatment, we have no way of judging whether its representations are based on pure chance results or on demonstrated efficacy. We have also no data that would definitely warrant either a wholesale or a restricted use of the method in general, although it is obvious that many persons believe that they were cured of divers diseases, and certain phenomena actually have occurred.

On the surface it would appear that it can do no real harm so long as it remains within rational limits; but it is also obvious that when it is carried into absurdities, as is frequently the case, it can become very dangerous. It is remarkable that the entire matter should be so loosely controlled. To place emphasis on the mental side of life is most important, and when this emphasis includes a sound philosophy and application of common sense, its contribution can hardly be overestimated. But when it results in the promiscuous teaching and practicing of mental tricks and self-delusion, it is a positive menace. To disguise such practice in the name of religion or of science as a means of capitalizing the credulity of the ignorant is despicable.

The newer movements within the church are in the same position as are the older movements independently organized. We can pass no judgment on them except from a theoretical point of view until some effort at a reliable evaluation of their work has been made. A similar statement applies also to the more general uses of religion as a therapeutic or reconstructive agent. With so many other factors involved, without controlled experimentation, judgment can be based only on opinion which is far from conclusive evidence.

Few workers in the religious field are aware of the nature of the problem with which they are dealing. This is quite natural, in view of its complexity. The physician would be at as great a disadvantage in the theological field. Knowing so little about medical science, it is not surprising that they are led astray by apparent similarities in their own teachings and those of the other field. The naïve Christian Scientist, for instance, might think that Mrs. Eddy's statement that poison has a harmful effect on the body only because every one believes that it will do harm is fully vindicated by the following report, which recently appeared in the New York *Times:*

> Stockholm, January 18.—By means of hypnotic suggestion, which made subjects believe that poisons administered to them were nothing but water, Dr. Henry Marcus and Dr. Ernst Sahlgren, Stockholm scientists, have been able to offset to a marked degree the effect of poisons on the human system. This was done in a series of experiments at the Karlclinska Medical Institute to determine the effect of hypnotism on organic diseases. The scientists put three subjects into hypnotic sleep and then administered drugs, carefully recording the effects on blood pressure and pulse both with and without suggestion. When a drug which acts to increase blood pressure was administered without suggestion, the blood pressure readings ranged between 109 and 130 and pulse readings from 54 to 100. With suggestion, the blood pressures were from 107 to 116 and pulse readings all less than 67.

Those who advocate religious therapy will do well to compare their methods with other methods which are similar, but which leave out the religious element for good reasons. In this connection, it is interesting to consider the results obtained through various systems of moralization and reëducation used in the practice of psychiatry. Another system in which religion is purposely eliminated is in Coué's method of auto-suggestion, which the religionists have so thoroughly embraced.

Some interesting data are being compiled by Dr. Shaler Lawton and his co-workers at the Columbia University College of Physicians and Surgeons. The results of Dr. Lawton's study may well serve as a warning. He is satisfactorily demonstrating, with certain cases for which medicine can do little, that the patient by exercising his morale may so completely control his attention that instead of fixating it on his symptoms, though they are of the most distressing nature, he believes himself cured and becomes entirely unaware of the fact that his physical condition remains the same and that his disease is running the natural course of its development. The religious healer, misled by the patient's controlled reaction to his symptoms, may be misleading him to let treatment effective in the earlier stages of the disease pass by until it is too late to help him. On the other hand, we must not overlook the fact that we may be considering an efficient method in the course of evolution, and that trial and error may naturally play an important rôle in its progress.

What this method will finally prove to be can be only a matter of conjecture until the situation has been subjected to more intelligent study. In all probability we shall find that there are indeed certain fundamental principles common to all aspects of the situation, but that they will have to be applied in a great variety of ways.

With so many varieties of human personality, the prerequisite state of mind that is essential to the operation of any method can probably be obtained only through a method of approach suitable to the individual make-up and background. This may be strictly religious in some cases, purely ethical in others, and entirely intellectual in others, while certain individuals of weak emotionalism may be susceptible to the influence of any strong or persistent appeal. If the basic principle is faith in the particular appeal of whatever form and the expectancy that develops, similar results are to be expected from widely differing methods adapted to the particular type of individual.

A broad appreciation of the situation would admit that perhaps no one method, whether religious or otherwise, can be expected to reach all types. It may very well be, however, that the religious appeal based on the functioning of an in-

stinctive mechanism is calculated to affect the largest number of persons, and that it may afford the soundest basis for the expectation of lasting results.

The medical profession has largely ignored and even denied the possibility of this method of approach. Meanwhile, as a reaction against the empiric method and the one-time drastic recourse to drugs, there has developed in some quarters considerable "therapeutic nihilism" except for the comparatively few diseases known by modern science to be susceptible to specific therapy. Still, the present materialistic trend tends too much to discredit methods of psychologic appeal to the alleviation of symptoms and the cure of disease. This may be because, in spite of the strong evidence that there is some relationship between mind and body, very little is actually known as to how close this relationship is, how this action takes place, and what its limitations are. But it cannot be overemphasized that the physician should take account of whatever influence there may be between mind and body. Much medical practice has admittedly a bad psychologic effect on the patient. Too little effort, for instance, is made to overcome the tendency to concentrate on symptoms of disease and to give the patient an intelligent grasp of the situation that confronts him. Some physicians will send the patient away with a theory or explanation of his disease not founded on any scientific data, which frequently creates or strengthens an attitude of apprehension and makes for continued invalidism or physical and mental ineffectiveness.

Psychologically speaking, certain physicians thus persistently apply the principle of negative suggestion in conditions in which it may produce real untoward effects. This is quite as true of many practices in psychotherapy as it is of minor material or physical therapeutic methods. The medical profession is largely culpable for the widespread rebellion against such methods, as evidenced by the enormous development of these various forms of faith healing.

The medical problem is to discover the underlying facts and principles and to inculcate those which are sound in a well-grounded system of practice which will recognize the true function of the mental and the spiritual as well as the material in the alleviation of human ills. Only in this way will it

be possible to confine the practice of these methods to those who can be depended on to use them with the unselfish motives characteristic of the best types of religious and medical practice.

Summary

1. The prevalence of religious healing and allied cults bears witness to the fact that the maintenance of individual health has become strongly associated in the minds of many people with religious and metaphysical ideas.

2. There is a great variety of sects and cults and movements appealing to this popular tendency to associate health and religion, such as Christian Science, Jewish Science, Divine Science or Divine Healing, New Thought, and Scientific Christianity. These are organized outside the church. In addition, there is considerable activity with regard to healing among Theosophists and Spiritualists. Moreover, the work has also been taken up in the orthodox churches, especially in the Episcopal Church. The Nazarene movement makes its appeal through the Episcopal Church. The Guild of Health confines its work to other Protestant churches. The novena, the application of relics, and visits to shrines, such as Lourdes and St. Anne de Beaupré, are well-established practices in the Roman Catholic Church. Individual clergy and laymen are also engaged in the work.

3. Some of these agencies are but little organized and have an ephemeral prosperity; but there are some that are well organized and with strong indications of being permanent. Christian Science especially has grown steadily since it originated in 1870, and New Thought has a similar history. The Nazarene movement and the Guild of Health have made a strong appeal within the church.

4. It is impossible to make any close estimate of the total number of adherents of this general movement, since some of the cults do not keep records of their membership. The number of Christian Scientists is estimated at 1,500,000. "Unity", a New Thought cult teaching "Scientific Christianity", is said to reach from three to five million people annually through its publications, lectures, and prayer services. The Nazarene movement now has about 7,000 members. If

the children and other dependents of adherents to these movements are counted, the number may reach 10,000,000. A wide appeal is also made through magazines and books. Some leaders make use of the radio to broadcast their teachings.

5. The attitude toward the medical profession ranges all the way from hearty coöperation, as in the case of certain individual workers and in some church agencies, to frank hostility, as in the case of Christian Science.

6. Enthusiastic testimonials and the apparently stable membership of some of these organizations (such as Christian Science, Unity, and other New Thought cults, also the Nazarene movement and Guild of Health) show that many persons believe themselves to derive great benefit from them. It should be acknowledged that, although some of their practices appear unscientific and even bizarre, others must be recognized as of possible benefit under certain circumstances.

7. The leaders of these movements either outside or inside the church are little disposed to set any definite limitations to the power and effectiveness of their therapy. The nature of the problem with which they are dealing is not fully comprehended by any of them.

8. Christian Science makes its approach through the concept that disease is "error", New Thought through the immanence of God, and others through still other metaphysical theories on which they base their practice; but practice itself shows considerable uniformity for all of these cults. It seeks to induce a cheerful, confident, serene state of mind, to remove the attitude of invalidism and similar negative emotions and beliefs, to promote relaxation, and to give full play to the suggestion or auto-suggestion of health. Various subjective mental states and religious ecstacy are more or less prominent in the treatment of patients.

9. Those resorting to religious and metaphysical healers often express dissatisfaction with physicians for a lack of sympathy and a tendency to build up an attitude of invalidism. Unless the physician is on his guard against giving negative suggestion, such an attitude can very easily be generated in the patient. Leaders of these cults use this as a strong argument against the medical profession.

10. Since religious healing has for the most part been carried on without expert diagnoses of the cases undergoing treatment and without expert determination of their condition after treatment, it is not possible to pass judgment on the merits, harmfulness, or limitations of this movement. Where spiritual therapy has been attempted under medical control, the results seem to indicate that:

(*a*) Neurotic patients, alcoholic habitués, drug addicts, and the like are sometimes improved by the treatment.

(*b*) The morale and comfort of a patient with organic disease may be improved, while the disease continues to run its course.

There is no way of evaluating the results obtained through religious healing as compared with those obtained with the same types of patients through non-religious suggestion. Controlled experiments are needed to obtain further data as a basis for judgment of the comparative efficacy of such treatment. Studies of suggestion of a non-religious nature as a therapeutic agent show that it is quite possible to teach the patient so to control his attention that he is able largely to ignore his symptoms.

11. A scientific study should sharply distinguish between the practice and the theories advanced by these various cults. Probably more attention should be accorded to the practice than to the theory. The theory is perhaps considered necessary as a means of getting hold of the patient, and this no doubt varies to a certain extent. Different persons require different "theories" or modes of approach. The question arises whether or not a scientifically sound basis could be formulated for whatever is useful in these practices, so that the essence of the practice (so far as it may be found good) might be employed with good conscience in treating the sick.

12. Further study should deal with the following problems:

(*a*) What is the common essential of these various practices?

(*b*) How can this essence be given a form and rationale suited to scientific use?

(*c*) What are the benefits, limitations, and dangers of these practices as established by a careful try-out under controlled conditions, carried on by physicians in coöperation with interested clergymen?

13. An adequate study will involve much work extended over a long period of time and carried on under unquestioned auspices by a most carefully selected personnel.

14. The whole problem is a serious one which the medical profession should not ignore.

FREQUENCY OF DEMENTIA PRAECOX IN RELATION TO SEX, AGE, ENVIRONMENT, NATIVITY, AND RACE *

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IN DETERMINING the rate of incidence of any mental disease, our only reliable data are those derived from hospital records of new cases admitted to institutions. These data are fairly accurate, but never give us complete information, as some mental patients are treated outside of institutions. It is well known that a considerable number of dementia-praecox patients of the milder sort are living at home or wandering from place to place. No accounting of these has ever been made. Many of them eventually enter hospitals for mental disease; many others die in the community from physical causes.

This study deals with dementia-praecox patients in hospitals and first admissions thereto, and makes no attempt to estimate the number of such patients living outside of hospitals. The data set forth are derived principally from the Federal Census of institutions for mental disease taken as of January 1, 1923, and from the statistical records of the New York State Hospital Commission.

SEX

Dementia praecox occurs more frequently among males than among females.

Of the 17,722 dementia-praecox first admissions to New York civil state hospitals during the period from October 1, 1915, to June 30, 1925, 9,431 were males and 8,291 females. The percentages were 53.2 and 46.8 respectively. The ratio of males to females was 113.7 to 100. In the general population of the state the ratio of males to females, in 1910, was 101.2

* Read at the annual meeting of the Association for Research in Nervous and Mental Diseases, New York City, December 28, 1925.

to 100; and in 1920, 99.8 to 100. Based on the Federal Census of 1920, the average annual rate of dementia-praecox first admissions per 100,000 of population during the above-named period among males was 18.6 and among females, 16.4.

In the Federal Census of first admissions to hospitals for mental disease in the United States, covering the calendar year 1922, the disparity in the sex distribution of dementia-praecox cases was much greater than that shown above for New York State. Of the 15,526 dementia-praecox first admissions reported, 8,950 were males and 6,576, females. The percentages were 57.6 and 42.4 respectively. The ratio of males to females was 136.1 to 100; in the general population of the United States the ratio of males to females in 1920 was 104.0 to 100. The rate of dementia-praecox first admissions in the United States in 1922 per 100,000 of population was 16.7 among males and 12.8 among females.

The sex distribution of dementia-praecox patients under treatment in hospitals for mental disease varies considerably from that of dementia-praecox first admissions. A census by psychoses of the patients on the books of the New York civil state hospitals taken as of June 30, 1924, gave a total of 24,871 dementia-praecox patients, of which 11,858 were males and 13,013 females. The percentages were 47.7 and 52.3 respectively. The ratio of males to females was 91.1 to 100. The excess of females among these patients under treatment is due to their greater longevity. As evidence of this fact, we find that the average age at death of dementia-praecox males who died in the civil state hospitals of New York in the fiscal year ended June 30, 1924, was 47.5 years, while that of the females was 52.1 years.

The number of resident dementia-praecox patients enumerated by the Federal Census of 1923 was 114,240, of which 60,653 were males and 53,587, females. The percentages were: males, 53.1, females, 46.9. The ratio of males to females was 113.2 to 100. Although there is an excess of males among resident patients of this group in the country as a whole, the relative difference between the numbers of the two sexes is not nearly so great as that shown for first admissions.

AGE AND SEX

The onset of dementia praecox occurs earlier in males than in females.

The average age at time of admission of the dementia-praecox patients first admitted to hospitals for mental disease in the United States in 1922 was 32.2 years. The only groups represented by younger average ages on admission were psychoses with psychopathic personality and psychoses with

TABLE 1. RATES OF DEMENTIA-PRAECOX FIRST ADMISSIONS TO NEW YORK CIVIL STATE HOSPITALS PER 100,000 OF GENERAL POPULATION, 1912–1918

Age group	*Number*			*Per 100,000 of population*		
	Males	Females	Total	Males	Females	Total
15 to 19 years	446	286	732	107.6	64.5	85.4
20 to 24 years	1,179	654	1,833	256.3	136.5	195.2
25 to 29 years	1,195	834	2,029	265.2	194.3	230.6
30 to 34 years	811	708	1,519	204.3	190.7	197.7
35 to 39 years	543	690	1,233	148.6	199.0	173.1
40 to 44 years	282	483	765	90.7	167.0	127.5
45 to 49 years	151	330	481	58.3	134.8	95.5
50 to 54 years	65	201	266	30.3	98.7	63.6
55 to 59 years	38	94	132	25.6	64.4	44.9
60 years and over	25	53	78	8.0	15.4	11.9
Total	4,735	4,333	9,068	103.9	96.3	100.1

mental deficiency. The average ages in these groups were 32.1 and 31.7 years respectively. The average age on admission of all first admissions was 42.6 years. The average age by sex is not given by the census report.

The average age of male dementia-praecox first admissions to the New York civil state hospitals for the firscal year ended June 30, 1925, was 30.6 years and of female dementia-praecox first admissions, 36.4 years. The difference in the average ages of the two sexes on admission probably corresponds with differences of age at onset of the disorder. Data throwing some light on this matter are given in Table 3 (page 600).

In a special study [1] of 9,124 dementia-praecox first admissions made by the author and William J. Nolan in 1919, it was

[1] "Sex, Age, and Nativity of Dementia Praecox First Admissions to the New York State Hospitals, 1912 to 1918", by Horatio M. Pollock and William J. Nolan. *State Hospital Quarterly*, Vol. 4, pp. 498–516, August, 1919.

found that the rate of admission of males was much higher than that of females in the age groups from 15 to 34 years and much lower in the age groups above 34 years. Of the 9,124 cases, 8 males and 11 females were under 15 years of age. The others were distributed by age and sex as shown in Table 1.

The highest rate of admissions among males—265.2—is found in the age group 25 to 29 years; the highest rate among females—199.0—occurs in the age group 35 to 39 years. The

TABLE 2. AGE AND SEX DISTRIBUTION OF DEMENTIA-PRAECOX FIRST ADMISSIONS, UNITED STATES * 1922

Age group	*Number*		*Rate per 100,000 of population*	
	Males	Females	Males	Females
Under 15 years	14	15	0.1	0.1
15 to 19 years	688	435	14.8	9.2
20 to 24 years	1,795	878	39.8	18.6
25 to 29 years	2,001	1,210	44.3	26.7
30 to 34 years	1,640	1,187	40.0	30.3
35 to 39 years	1,153	1,000	28.5	27.2
40 to 44 years	681	678	20.9	22.3
45 to 49 years	352	519	11.4	19.7
50 to 54 years	232	332	9.2	15.2
55 to 59 years	110	147	5.9	8.8
60 to 64 years	57	68	3.6	4.9
65 to 69 years	30	30	2.8	3.0
70 years and over	36	29	2.6	2.0
Total	8,950	6,576	16.7	12.8

* Exclusive of Montana.

rate among males declines rapidly after age 35 is reached, while the rate among females declines quite gradually beyond the age of 40 years. In age group 50 to 54 years the rate for females is three times as high as that for males.

The dementia-praecox first admissions to hospitals for mental disease in the United States in 1922 were distributed by age and sex as given in Table 2.

In Table 2 the highest rates among males are found in the age groups from 20 to 34 years and among females in the age groups 25 to 39 years. In the age groups from 20 to 34 years the rates among males are very much higher than those among

females; in the age groups from 40 to 69 years the rates for females are the higher.

The correspondence of results in these two tables, each of which deals with several thousand cases, indicates that sex is a factor of significance in dementia praecox. The low rates during the years of puberty and adolescence show conclusively that the old term *adolescent insanity* in a strict sense covered only a small portion of the cases now included in this group.

The disorder as judged from first admissions is apparently most prevalent among males between the ages of 20 and 40

TABLE 3. DURATION OF ATTACK PREVIOUS TO ADMISSIONS IN CERTAIN GROUPS OF DEMENTIA PRAECOX FIRST ADMISSIONS TO NEW YORK CIVIL STATE HOSPITALS, 1925

Age group	Males*	Females*	*Average duration of attack previous to admission, years*	
			Males	Females
15 to 19 years	89	36	0.9	0.6
20 to 24 years	166	91	1.4	1.5
25 to 29 years	156	145	1.7	1.6
30 to 34 years	131	144	2.1	1.9
35 to 39 years	110	155	2.5	3.0

* Includes only cases in which the duration of attack previous to admission was ascertained.

and among females between the ages of 25 and 40. The beginnings of the disorder, of course, antedate the first admission, but the incipiency of dementia praecox is so obscure that definite data relating thereto cannot be obtained. We have, however, collected some statistics relative to the duration of attacks previous to admission. Such duration varies with the age on admission, being much longer in the advanced age groups. Tabulation of the ascertained cases among the first admissions to the New York civil state hospitals of 1925 in the age groups under 40 years gives the results shown in Table 3.

The differences between the two sexes with respect to duration of attack previous to admission is slight and is not a factor of importance in the explanation of the older age of females on admission.

SEX, AGE, AND ENVIRONMENT

Dementia praecox is more prevalent in cities than in rural districts.

In a study[1] of 32,355 consecutive first admissions to the civil state hospitals of New York in the fiscal years 1915 to 1920, including 8,518 cases of dementia-praecox, it was found that the average annual rate of dementia praecox first admissions per 100,000 of population was 19.1 in cities and 7.8 in rural districts. In New York City the average annual rate was 21. In cities of the state classified with respect to population, the rates were as follows:

Cities having population of	*Average annual rate of dementia praecox per 100,000 of population*
Over 175,000	20.7
50,000 to 175,000	15.2
20,000 to 50,000	11.7
10,000 to 20,000	12.3

Apparently the stresses of life in large cities are positive factors in the causation of this disorder. The only recent data available concerning the sex distribution of the population of the urban and rural districts of the state are those contained in the 1920 census. The rates of first admissions with dementia praecox in the state in that year were as follows:

DEMENTIA-PRAECOX FIRST ADMISSIONS TO NEW YORK CIVIL STATE HOSPITALS, 1920

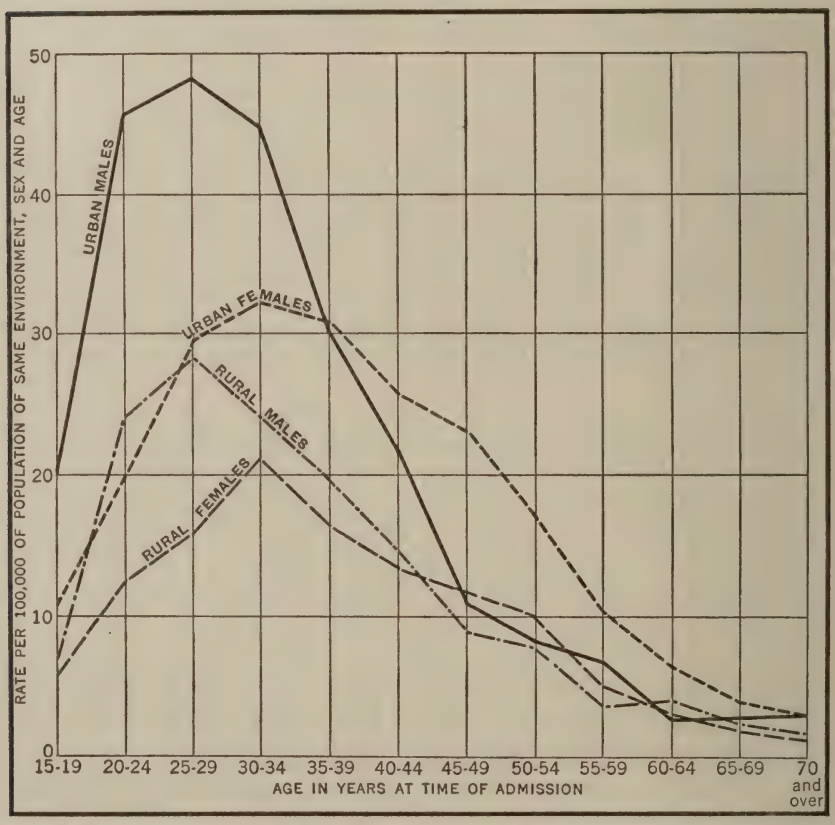
	Males		*Females*	
	Number	Rate per 100,000 of population	Number	Rate per 100,000 of population
Urban	912	21.4	826	19.1
Rural	83	9.0	93	10.6

More comprehensive data relating to environment, sex, and age of dementia-praecox first admissions are given in the special Federal Census report of 1923 concerning patients in institutions for mental disease. Table 4 is derived from such report (page 604).

[1] "Mental Disease in Cities, Villages, and Rural Districts of New York State, 1915–1920", by Horatio M. Pollock and William J. Nolan. *State Hospital Quarterly*, Vol. 7, pp. 38–59, November, 1921.

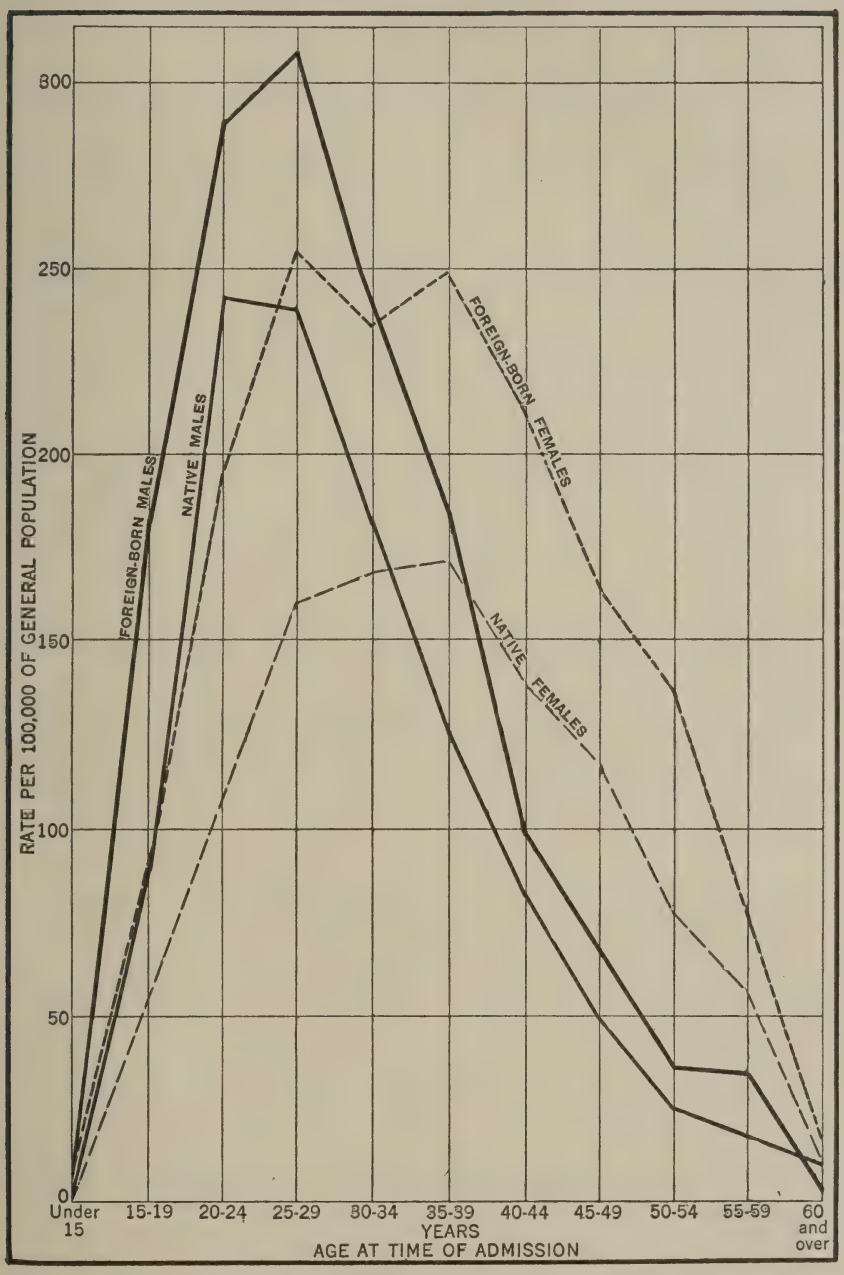
Comparing rates for the urban and rural population, we find that the rates for the former are much higher than those for the latter in every age group. The general average rate for males is higher than that for females in both urban and rural environment. Among the urban population, the rates for males are higher than those for females in the age groups under 35 years and lower in the age groups from 35 to 70 years. Among the rural population the rates for males are higher than those for females in the age groups under 45 years and lower in the groups from 45 to 60 years. (See Chart 1 below.)

CHART 1



RATES OF DEMENTIA-PRAECOX FIRST ADMISSIONS IN URBAN AND RURAL COMMUNITIES IN UNITED STATES, 1922.

CHART 2



COMPARISON BY SEX AND AGE GROUP OF RATES OF NATIVE AND FORIEGN-BORN DEMENTIA-PRAECOX FIRST ADMISSIONS PER 100,000 OF THE GENERAL POPULATION OF SAME SEX, AGE AND MATURITY, NEW YORK, 1912-1918.

TABLE 4. RATES OF DEMENTIA-PRAECOX FIRST ADMISSIONS TO INSTITUTIONS FOR MENTAL DISEASE IN THE UNITED STATES PER 100,000 OF POPULATION OF THE SAME ENVIRONMENT, SEX, AND AGE

Age period	*Urban*		*Rural*	
	Males	Females	Males	Females
15 to 19 years	20.1	11.0	7.7	6.1
20 to 24 years	46.3	20.3	24.8	12.9
25 to 29 years	48.7	29.9	29.1	16.4
30 to 34 years	45.3	32.8	24.7	21.7
35 to 39 years	30.9	31.3	20.2	16.7
40 to 44 years	22.4	26.0	14.8	13.6
45 to 49 years	11.0	23.3	8.9	11.7
50 to 54 years	8.3	17.5	7.8	10.3
55 to 59 years	7.0	10.5	3.6	5.1
60 to 64 years	2.6	6.3	3.8	2.8
65 to 69 years	2.5	3.7	2.2	1.9
70 years and over	2.9	2.8	1.4	1.0

NATIVITY AND RACE

Dementia praecox is more prevalent among the foreign born than among the native population.

The number and rate of *dementia-praecox* first admissions to institutions for mental disease in the United States in the large nativity, parentage, and race groups are shown in Table 5.

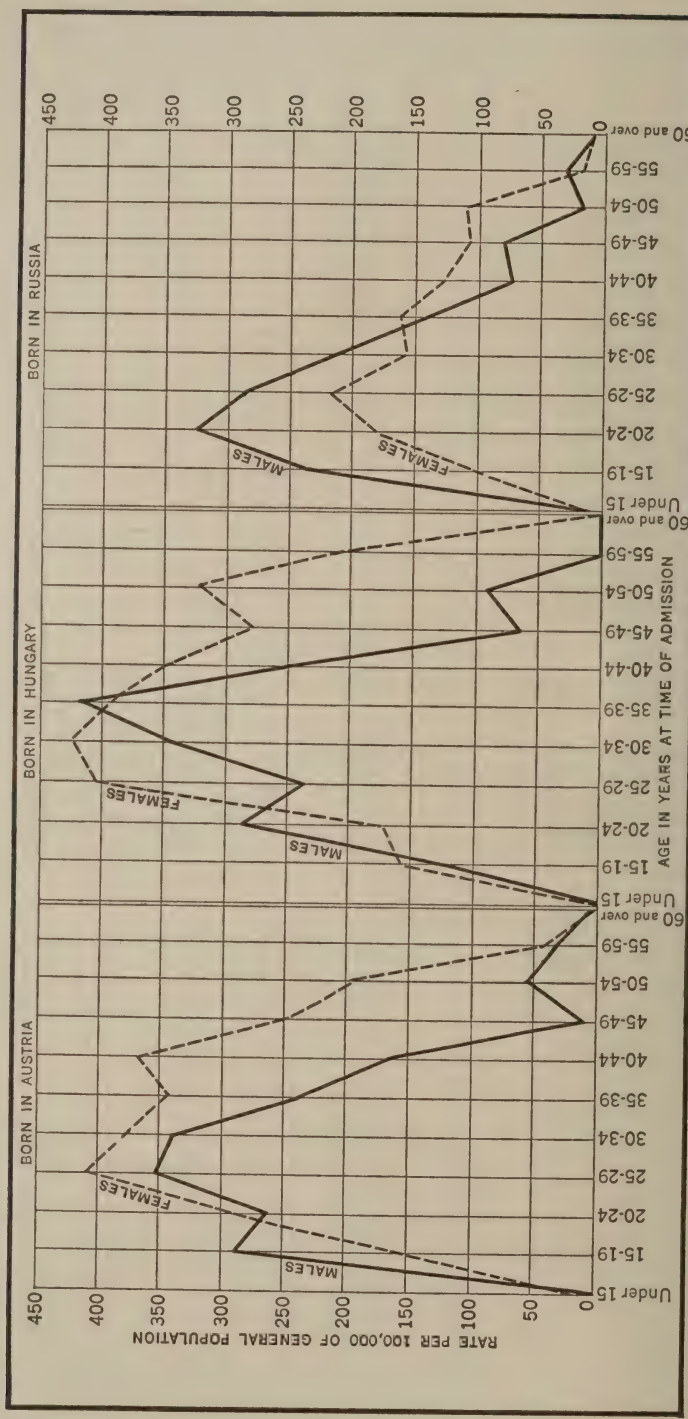
TABLE 5. NATIVITY AND RACE OF DEMENTIA-PRAECOX FIRST ADMISSIONS, UNITED STATES, 1922

	Number			*Per 100,000 of same race and nativity*		
	Males	Females	Total	Males	Females	Total
Native white	5,687	4,188	9,875	14.0	10.5	12.2
Native white of native parentage	3,001	2,413	5,414	10.2	8.4	9.3
Native white of foreign or mixed parentage	1,568	1,292	2,860	14.0	11.4	12.7
Foreign-born white	2,149	1,502	3,651	28.8	24.4	26.8
Total white	8,200	5,935	14,135	17.0	12.9	15.0
Negro	685	628	1,313	13.2	11.9	12.5
Nativity unknown	364	245	609	...	...	...
Parentage unknown	1,118	483	1,601	...	...	...
All classes	8,950	6,576	15,526	16.7	12.8	14.8

TABLE 6. NATIVITY DISTRIBUTION OF FOREIGN-BORN DEMENTIA-PRAECOX FIRST ADMISSIONS WITH RATES PER 100,000 OF POPULATION OF SAME NATIVITY, UNITED STATES, 1922

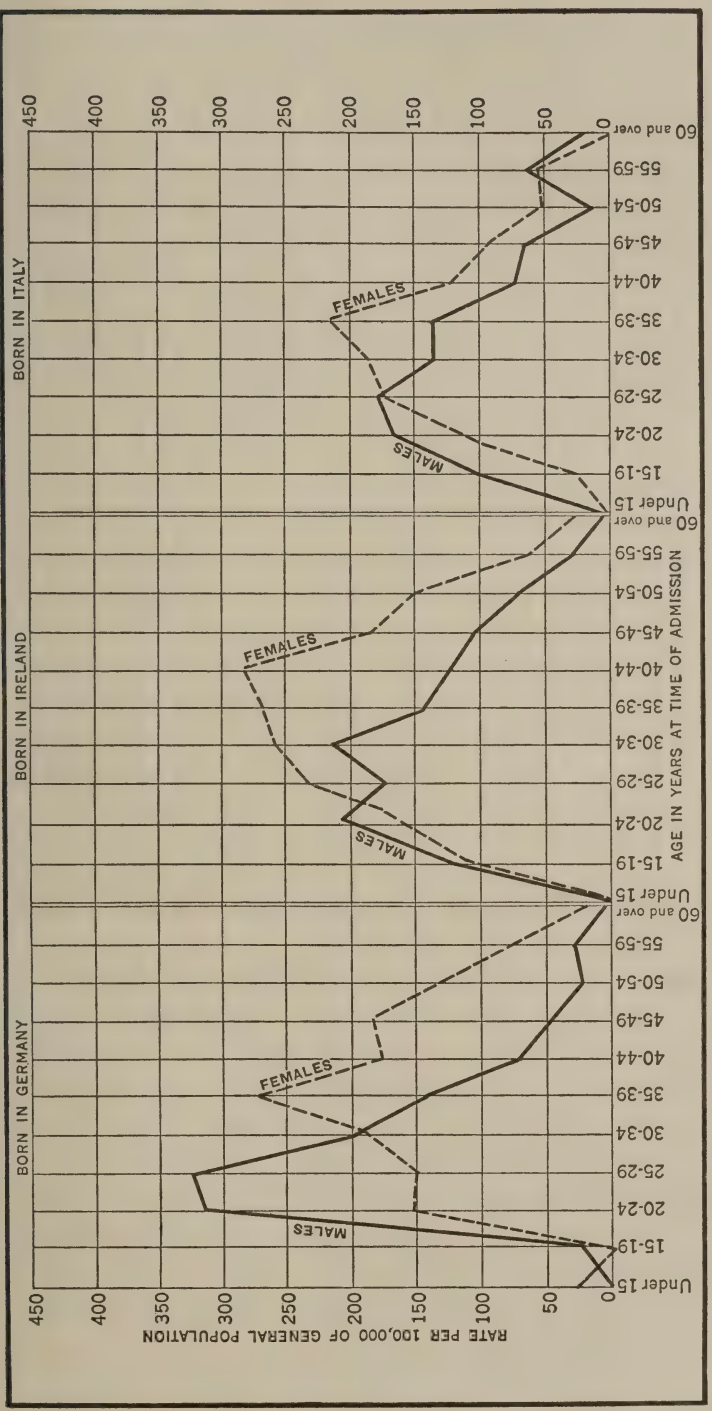
	Number	*Per 100,000 of population*
Northwestern Europe		
England	108	13.4
Scotland	36	14.3
Wales	8	12.9
Ireland	329	31.9
Norway	74	20.9
Sweden	182	29.4
Denmark	31	16.7
Netherlands	20	15.4
Belgium and Luxemburg	11	14.7
Switzerland	33	28.1
France	30	19.7
Central Europe		
Germany	245	14.6
Poland	401	35.2
Czechoslovakia	79	21.9
Austria	341	59.6
Hungary	114	28.8
Jugo-Slavia	34	20.5
Eastern Europe		
Russia	473	33.9
Lithuania	54	40.0
Finland	84	57.4
Roumania	28	27.2
Southern Europe		
Greece	101	57.9
Italy	395	24.6
Spain	24	48.7
Portugal	10	14.8
Other Europe	16	....
Canada	186	16.9
Mexico	74	15.5
Armenia	25	68.3
Syria	12	23.1
Turkey in Asia	18	209.1
All other countries	171	....
Total	3,747	27.5

CHART 3



RATES BY SEX AND AGE GROUP OF DEMENTIA-PRAECOX FIRST ADMISSIONS AMONG THE FOREIGN-BORN GENERAL POPULATION OF YORK STATE OF SAME SEX AND AGE, 1912-1918.

CHART 4



RATES BY SEX AND AGE GROUP OF DEMENTIA-PRAECOX FIRST ADMISSIONS AMONG THE FOREIGN-BORN GENERAL POPULATION OF NEW YORK STATE OF SAME SEX AND AGE, 1912-1918.

In the groups shown in Table 5 (page 604), the lowest rates are found among native whites of native parentage and the highest rates among foreign-born whites. In every group the males have higher rates than the females.

Rates by sex and age group of native and foreign-born first admissions to New York state hospitals are shown in Chart 2 (page 603). It will be observed that the rates for the foreign born exceed those for the native population in both sexes and in every age group under 60 years.

The rates for the foreign born in the United States classified by country of birth are given in Table 6 (page 605). The sex distribution of these patients is not available.

The numbers in Table 6, in some instances, are too small to make the rates of general significance. Some allowance must also be made for possible inaccuracies in reporting nativity due to changes made in boundary lines following the late war. The rates are also influenced by the age distribution of the immigrant population from the several countries. After making due allowance for these factors, it seems safe to say that there is a high rate of dementia praecox among the population of the United States from the following countries: Ireland, Poland, Austria, Hungary, Russia, Finland, Greece, and Italy. This conclusion is in part confirmed by the study [1] above referred to, which gives rates by age groups for the foreign born from five of the above named countries. (See Charts 3 and 4, pages 606 and 607.)

As immigrants settle largely in cities, the question naturally arises: Is the high rate of dementia praecox in cities due merely to the presence of the foreign born therein? To answer this question we made a study of the dementia-praecox first admissions to the civil state hospitals of New York in 1925. The results are shown in Table 7 (page 609).

From the data given in Table 7, it will be observed that the rates in each nativity group are higher among the urban than the rural population, and that the rates for foreign-born whites are more than twice as high as for native whites of native parentage in both country and city.

[1] See note, page 598.

TABLE 7. ENVIRONMENT, NATIVITY, AND RACE OF DEMENTIA-PRAECOX FIRST ADMISSIONS TO NEW YORK STATE HOSPITALS, 1925

	Urban						*Rural*					
	Number			Per 100,000*			Number			Per 100,000*		
	M	F	T	M	F	T	M	F	T	M	F	T
Native white of native parentage.....	147	144	291	15.6	14.5	15.1	38	38	76	7.9	8.2	8.0
Native white of foreign or mixed parentage.	285	259	544	26.1	21.7	23.8	27	23	50	17.3	15.5	16.4
Foreign born white.....	450	408	858	34.1	33.0	33.6	19	21	40	17.8	23.0	20.2

* Federal census, 1920.

RACE

Dementia praecox is relatively more frequent in some races than in others.

Race studies in this country, except in the principal color groups, are unsatisfactory because no basic data exist relative to the distribution of the various European races in the population.

The Federal Census of 1923 gives rates in principal racial groups of first admissions with dementia praecox per 100,000 of same race, as follows:

Race	*Males*	*Females*	*Total*
White	17.0	12.9	15.0
Negro	13.2	11.9	12.5
Indian	8.4	5.3	6.9
Chinese	43.3	39.1	42.8
Japanese	18.1	5.3	13.6

The high rates among the Chinese are partly due to their age distribution, there being few children among them. The low rates among Indians may signify either comparative freedom from the disorder or lack of hospital treatment.

In the data compiled for the New York State Hospital Commission, we find a marked difference in the per-cent distribution of the psychoses of first admissions of the several European races. The percentages of dementia-praecox cases among the first admissions of the principal races, in 1924,

were as follows[1]: German, 26.2; Hebrew, 35.6; Irish, 23.5; Italian, 28.9; Slavonic, 41.8. The figures indicate that dementia praecox is relatively more frequent in some races than in others, but they cannot be used to compare absolute rates of incidence.

WHITES AND NEGROES

Dementia praecox is more prevalent among Negroes than among whites.

Census data relating to psychoses of first admissions of Negroes and whites are unsatisfactory for comparative purposes, as in several states unequal provision is made for the treatment of mental patients of the two races. It is well known that hospitals for Negro patients in the South are inadequate. The rate of first admissions of Negroes in the section of the country having the largest Negro population is, therefore, much smaller than in the states that admit Negroes on the same terms as whites. As given above, the rate of dementia-praecox first admissions in the United States in 1922 per 100,000 of population was 12.5 among Negroes and 15.0 among whites. In New York State in 1924 the rate was 48.6 among Negroes [1] and 16.9 among whites. In Illinois, in 1924, the rates were 57.1 and 15.6 respectively.[2]

The high rates among Negroes in these two representative states, which make no racial distinctions in admitting patients, indicate a higher general rate of dementia praecox among Negroes than among whites.

CONCLUSIONS

1. Dementia praecox occurs more frequently among males than among females.
2. The onset of dementia praecox occurs earlier in males than in females.
3. Dementia praecox is more prevalent in cities than in rural districts.

[1] Annual Statistical Review of the New York State Hospital Commission, 1924.
[2] Report of Statistician, Illinois Department of Public Welfare, 1924.

4. Dementia praecox is more prevalent among the foreign-born than among the native population in both city and country.
5. Dementia praecox is relatively more frequent in some European races than in others.
6. Dementia praecox is more prevalent among Negroes than among whites.

ABSTRACTS

MENTAL DISEASE AMONG NEGROES IN THE UNITED STATES. By Horatio M. Pollock. *The State Hospital Quarterly*, 11:47–66, November, 1925.

The main source of the data presented in this study was the special census of institutions for mental diseases taken by the Federal Census Bureau as of January 1, 1923, which included both public and private institutions in every state in the Union except Montana.

In the Federal Census of 1920, the Negro population of the country is given as 10,463,131, or 9.9 per cent of the total population. Over four-fifths of the Negroes, however, are concentrated in the states of the South Atlantic, East South Central, and West South Central divisions. In these three divisions combined, they constitute about 27 per cent of the population as compared with less than 3 per cent in all the other geographical divisions. This fact has an important bearing upon the present study since the southern part of the country has made less institutional provision for mental patients than the other sections, and its provision for Negro patients is even less adequate than for white patients.

The special census of 1923 showed that the relative increase in the number of Negro patients in institutions for mental disease from 1910 to 1923 was greater than that of white patients. In 1910 the number of Negro resident patients was 12,910—6.9 per cent of the total resident patients—and the number of white patients 174,224, or 92.8 per cent of the total. In 1923 the figures were for the Negroes 20,084, or 7.6 of the total, and for the whites 244,968, or 92.2 per cent of the total, representing an increase in the thirteen years of 55.6 per cent in Negro and 40.6 per cent in white patients.

The rate of resident patients per 100,000 of population of the same race, computed from the data of the 1923 census, was 192.00 among Negroes and 258.3 among whites. This might seem to indicate a greater prevalence of mental disease among Negroes than among whites, but a closer analysis of the data yields evidence to the contrary. In 37 of the 47 states included in the census the rate of Negro resident patients was greater than that of white patients. In Massachusetts, for example, the rate of Negro patients was 644.4 and that of white patients 408.8; in New York, these rates were 529.0 and 391.9 respectively. The only states in which the rate of resident white patients exceeded that of Negro patients were in the southern section

of the country, in which, as has been pointed out, institutional care for Negroes is inadequate. It seems, therefore, not unreasonable to assume that if institutional care were provided for the two races equally, the rate of Negro resident patients would everywhere be higher than the rate of white patients.

But the data as to resident patients, while they are an indication of the extent to which provision is made for mental patients in the various parts of the country, do not give much of an idea of the incidence of mental disease. The data on first admissions are a better index of this. But here again the unequal provision for mental patients made by the several states must be taken into consideration. In 1922 the general rate of first admissions per 100,000 of population of the same race was 56.4 for Negroes and 69.5 for whites, but the rates for both Negroes and whites in the several states vary widely from the general rates, the variations being especially great among Negroes. In all the geographical divisions of the country except the three already mentioned—the South Atlantic, East South Central, and West South Central—the rates were higher for Negroes. New Hampshire, Vermont, and South Dakota had no Negro first admissions during 1922, and no figures were given for Montana. In all the other Northern states except Wyoming—which had only one Negro first admission—Minnesota, and Missouri, the rate for Negroes was the higher. This was the case also in seven of the Southern states—Delaware, Virginia, West Virginia, Florida, Kentucky, Tennessee, and Alabama. In all, the rates were higher among Negroes in 31 states.

Doctor Pollock attributes the high rate of mental disease among Negroes to several factors: "The Negro race is probably less stable than the white race. As most Negroes live a marginal existence, the occurrence of mental disease is a severe tax on the family resources, and it is probable that admission to an institution, if one is available, is resorted to more frequently than in the case of the whites. The Negroes in the North especially are city dwellers and are subjected to the stresses of city life, which many of them are ill-adapted to withstand. The climate of the North brings an added stress to the Negro race, which originally developed in warmer regions."

With reference to the low rates for Negroes generally reported throughout the South, Doctor Pollock quotes the following statement from the special census of patients with mental disease taken in 1910:

"The fact that the Negroes in the South have a lower rate of admission than the whites does not necessarily indicate that insanity is less prevalent in one race than in the other. The difference in the

relative numbers admitted to asylums for the insane may be influenced by the local distribution of the two races, by their practice as regards taking steps to have the insane placed under institutional care or restraint, and by the relative sufficiency of the provisions made for caring for the insane of each race. What the effect of such factors may be it is difficult to determine, but it seems probable that they furnish at least a partial explanation of the differences between the two races as regards the proportionate numbers admitted to institutions for the insane. It is furthermore probable that, because of illiteracy, poverty, and ignorance among the Negroes, cases of insanity, especially those which are forms of senile dementia, are less likely to be diagnosed or detected in this race than among the whites."

Taking into consideration all these facts, Doctor Pollock draws the general conclusion that mental disease is probably more prevalent among Negroes than among whites.

A comparison by age groups of the Negroes, native whites, and foreign-born whites resident in mental hospitals on January 1, 1923, shows higher rates per 100,000 of population of the same age, race, and nativity for Negroes than for either native or foreign-born whites in the early age groups. In the group under fifteen, the rate was 3.5 for Negroes, 1.6 for native whites, and 2.7 for foreign-born whites; in the fifteen-to-nineteen-year group, the rates were respectively 53.2, 33.6, and 52.3. In every succeeding five-year age group the foreign-born whites had a markedly higher rate than either the Negroes or the native whites. But the Negroes had higher rates than the native whites in all the groups up to thirty-five years and in the forty-to-forty-four-year group. The general average was 192.0 for Negroes, 208.7 for native whites, and 510.4 for foreign-born whites.

Among first admissions during 1922, the Negroes had higher rates than the native whites in the age groups up to thirty-five, from forty to forty-four, and from sixty-five to seventy-nine. The rates for Negroes were lower than the rates for foreign-born whites, however, in every age group except those from sixty-five to seventy-four years. The rate for foreign-born whites exceeded the rate for native whites in every group except that from fifty to fifty-four. The general average rates among first admissions were 56.4 for the Negroes, 56.5 for the native whites, and 112.4 for the foreign-born whites.

Of the 20,084 Negro resident patients included in the special census, 10,265 were males and 9,819 were females; of the 5,896 Negro first admissions, 3,300 were males and 2,596 females. The psychoses most numerously represented among the male first admissions were dementia-praecox (685 cases), general paralysis (514 cases) and manic-depressive psychoses (471 cases); among the female first

admissions, dementia praecox (628 cases), manic-depressive psychoses (613 cases), and senile psychoses (207 cases).

A per-cent distribution of Negro and white resident patients by sex and psychosis gave the Negroes of each sex higher percentages in the general paralysis, cerebral syphilis, and manic-depressive groups than the corresponding sex among the white patients. Especially noteworthy was the high percentage of manic-depressive psychoses among the Negro females—26.1 per cent as compared with 16.8 per cent among the Negro males, 18.6 per cent among the white females, and 12.2 per cent among the white males. The percentages in the dementia-praecox group were lower among the Negroes of both sexes—36.1 per cent for the males, and 36.8 per cent for the females as compared with 42.5 per cent for the males and 40.8 per cent for the females among the white patients. The percentage of alcoholic psychoses among the white males was double that among the Negro males—3.6 as compared to 1.8; it was the same—0.6 per cent—for the females of both races.

The per-cent distribution by psychoses of first admissions does not correspond very closely with that of resident patients. The latter represent the residue of the admissions of several years, the former the new cases that entered during the census year. The percentage of general paralysis, for instance, is much higher for both races among first admissions—11.6 per cent for the Negroes and 8.5 per cent for the whites as compared with 4.4 per cent for the Negroes and 3.6 per cent for the whites among resident patients. On the other hand, the percentage of dementia praecox was lower in both races among first admissions—22.3 per cent for the Negroes and 21.6 per cent for the whites as compared with 36.5 per cent for the Negroes and 41.7 per cent for the whites among resident patients. The percentage of manic-depressive psychoses was lower among first admissions than among resident patients in the case of the Negroes (18.4 per cent as compared with 21.3 per cent) and slightly higher in the case of the whites (15.7 per cent as compared with 15.3 per cent).

The rate of first admissions per 100,000 of general population was lower among Negroes than among whites in all the large groups except those of general paralysis, cerebral syphilis, and epileptic psychoses. In the alcoholic group it was 1.0 for the Negroes and 2.7 for the whites. But these rates cannot be taken as indicative of the real state of affairs in view of the inadequate institutional provision for Negro patients in the South. The rates for Negroes would undoubtedly be much higher if Negroes were admitted as freely as whites to the mental hospitals of the South. As evidence of this, Doctor Pollock offers the data from New York State, in which the

rates of Negro first admissions are higher than in the country as a whole in almost every psychotic group. He thinks it probable that the same situation obtains in other Northern states.

The general recovery rate in 1922 was 14.0 per 100 admissions of the same race for the Negroes and 13.6 for the whites, but the general improvement rate was lower for the Negroes—19.0 as compared with 27.7 for the white patients. The Negroes had higher recovery rates in the alcoholic and manic-depressive groups and a lower rate in the paranoic group. The whites had higher improvement rates in every group of psychoses except that of psychoses with mental deficiency.

The general death rate among Negro patients in 1922 was much higher than among white patients. The Negro rate was 96.1 per 1,000 patients under treatment and the rate among whites 72.5. The rates for the males of the two races were 105.8 among the Negroes and 78.1 among the whites, and for the females 85.5 among the Negroes and 65.9 among the whites. These rates correspond to some extent to the rates among the same classes in the general population, in which the Negro death rate is higher than the white and the death rate among males higher than that among females. There was great variation in the rates of the several psychotic groups, the rates in the organic and somatic-disease groups being much higher for both races than those in the so-called functional groups. The rate for Negro patients was higher than that of white patients in almost every group.

Psychology and Social Hygiene. By Hugh Crichton Miller, M.D. *Journal of Social Hygiene*, 12:14–24, January, 1926.

This address, delivered before a conference of the British Social Hygiene Council, is a discussion of the modern gospel of freedom, particularly in its bearings upon the problem of social hygiene. Public opinion has been misled with regard to freedom both by politicians and by many psychologists, who talk as if freedom were an end in itself. As a matter of fact, freedom, "whether of the individual or the community, has no value except in so far as it leads to the individual or community finding greater value in his or their lives. In so far as freedom is largely the necessary condition of an individual finding the greatest value in his life, freedom is good; in so far as it only leads to license, it is a freedom which is of a negative value." It is the abuse of freedom by many individuals that leads to the statement: "What is wrong with the young people of to-day is that they have too much freedom."

To attempt to carry on social-hygiene work from this reactionary point of view, however, would be fatal to the cause. In a generation of young people who have "freedom on the brain" progress must

come, not by curtailing freedom, but by utilizing it. The same freedom which can result in "a tremendous slackening of the moral code, a tremendous increase in venereal disease, a tremendous increase in disastrous marriages" can also be made a means to "a progress in the community with regard to sex and marriage that has never been attained before", and it is the task of social hygiene to help bring this about.

The "Victorian generation" had its faults, but it must be admitted that the Victorian parent, if he believed in disciplining his children, believed also in self-discipline. "All that is past, and we are seeing already a generation of fathers and mothers springing up who, while they are preaching freedom for their children, are claiming freedom loudly for themselves, and are showing the utmost disinclination to exercise self-restraint for themselves. . . . If you talk to people who are calling out for freedom so loudly to-day, and if you really analyze what their claim to freedom means, you will find it is largely a freedom to attain what they believe to be happiness by a free expression of their own appetites and desires, with a glorious inconsideration of the claims of others."

It is useless to try to combat such ideas of freedom with discipline and authority. "Freedom like that", Doctor Miller asserts, "has got to go through—and I think history teaches us this—the ghastly phases of infantile social disaster, in which a new social life has to reach maturity through experiments that have been failures; and there is a great deal in the freedom of this generation, especially with regard to morals, that is of the nature of an experiment, an experiment in license and an experiment in selfishness." But, Doctor Miller continues, the remedy for all this lies, not in taking away freedom, but in an infinitely more difficult course—through the implanting in the young generation of an ideal of self-realization so inspiring that their freedom will be used as a condition of true self-realization. It is not enough to hold up before them traditional ideals and standards of conduct. That was the mistake of the Victorian generation. Something much more dynamic and progressive is needed if the crusade of social hygiene is to get anywhere. Venereal-disease centers, lectures, pamphlets have their part to play, of course, but what really counts is the dynamic power of the ideal in the minds of the young generation.

It is not, Doctor Miller points out, merely a question of right and wrong. "If you say conduct is right, and conduct is wrong, if you are perpetually posing as Moses coming down from the Mount with the Tables of Commandments in his hands, and losing his temper when he saw that the Children of Israel had sinned against the Lord of Hosts, you are going to get results not much better than the last

generation. We have to inspire them with something quite different for this reason: that when conflict arises in the human mind, there is an invariable tendency to rationalize. This simply means that we invent specious excuses and specious excuses are readily found when the conflict is laid as between an individual's happiness and a categorical morality. If you are going to lay the conflict that way, you are going to give your young men and your young women ample opportunity for rationalizing. They will be able to invent endless excuses—some more specious than others, but all more or less specious—which will result in the conflict going the way that their instinctive nature demands; and the result of that is disappointing venereal-disease statistics, disappointing divorce-court statistics, and the race has not got much further forward. Let us rather put the conflict on different ground; let us make an individual realize that to be instinct-driven is on the whole a low ideal to accept for oneself; let us make him realize that happiness is not a thing which is to be measured in terms of satisfaction of biological impulses. . . ."

A great deal is being said about the danger of repression, but too often the difference between self-restraint and repression is not made sufficiently clear. "Self-restraint means you fight the battle and you know what you are doing; it is a battle out in the open and you know who your enemy is and you know where he is and you know all about it. But repression is a perfectly different thing, it is like a revolution. It is an indefinable menace which you tend to meet by saying, 'All is well; all is well.' The Czar Nicholas gave a magnificent example of repression. He continued to consider all was well in his kingdom until the whole thing went up in a flash. He didn't see and wouldn't see the enemy within that was threatening him. It is the same with us. Repression is when we refuse to see the enemy within us. There are pure young men and saintly old ladies alike who take up this attitude of repression, who deny that their biological impulses have ever given them any trouble, and who feel that there is something terribly derogatory to their spiritual status in admitting that they have ever had a pitched battle between the biological impulse and the ethical ideal." But that kind of battle cannot be successfully waged except in the open. Carried on on the underground principle, on the principle of refusing to acknowledge that it is there, it results not, perhaps, in the kind of disease social hygiene is engaged in fighting, but in a disease of another sort—neurosis.

But the nervous diseases that arise from sex repression are no argument against self-restraint in sex matters. From his own practice, Doctor Miller cites instances of the unfortunate effects of the license that is miscalled freedom both upon the individuals who claim it for

themselves and upon their children, whose natural tendency to follow in their parents' footsteps meets with no understanding and sympathy or even tolerance from those parents.

In conclusion, Doctor Miller touches upon the relation of Christianity to sex morality, pleading for a broader point of view than that of any particular sect or denomination: "In this task of ours let us at any rate see that the gospel that we are preaching is one which can cover every denomination that is willing to come in with it; it must not be placed upon any sort of narrow religious basis at all; and don't let us think that we are in any way weakening the cause of religion if we do not continually claim progress in the name of Christianity. I know that there are a great many good people who feel that we ought always to be saying that and making every challenge in the name of Christianity. Now don't! I think if we could put this business of social hygiene to the rising generation in just the right way, we would find that the Christian churches would get an enormous influx of vitality; but if we are going to do it by specializing on one denomination, if we are going to say to the young people, 'We want you to keep straight because you musn't disgrace that Salvation Army badge you are wearing,' if we are going to do it that way, we are going to get at it from the wrong end, and once more we are going to make it easy for them to rationalize. Therefore, I say, do let us present this whole question to them on a basis of progressive evolutionary idealism, because I believe that is the only basis that is going to be strong enough to be effective."

Some Values of Institutional Training Shown by Reëxaminations. By Mary Vanuxem. *Ungraded,* 10:151–58, April, 1925.

In the summer of 1924 the Pennsylvania Village for Feebleminded Women (now the Laurelton State Village) undertook a retest of a number of the women of whom psychological studies had been made upon their entrance to the school four years before. The object of the retest was to determine whether the results of the education and training given to these women could be actually demonstrated by changes in their ratings. In order to have an accurate basis for comparison, the same tests were used as in the original examination—the Stanford revision of the Binet-Simon, the Kuhlmann tests, and various performance tests. The original study included fifty girls, the first fifty admissions to the school, but only thirty-nine of them remained in the institution at the time the retests were made.

In the Stanford-Binet tests, nine of the girls made ratings twelve months or more above those obtained in the first examination; the scores of the other thirty were either the same or less than twelve

months higher, but no girl received a lower rating than she had in 1920. An analysis of the nine cases in which the scores were higher shows that in two cases the increase was due to the absence of the emotional strain under which the girls were laboring at the time of the first testing. In the other seven cases, the improvement was evidently due to additional education and training. Six of the seven failed the first time in tests involving dates, vocabulary, reading, and so forth, which the academic training received in the school enabled them to pass in the second examination. The seventh girl, an idiot, whose mental age was 1 year, 8 months at the time of her admission and 2 years, 10 months on her retest, owed her advance mainly to the training given her by her associates and the employees of the school, though treatment for an abnormal thyroid gland was a contributing factor.

The greatest difference between the two examinations was in the performance tests. In the second examination, thirty-two girls surpassed their former scores by a year or more. Six received a rating less than twelve months higher, and one fell below her previous record.

The increase in ability shown by so large a proportion of the girls in the performance tests was probably due to four factors: (1) increased motor coördination as a result of training, (2) supervised play and games, (3) instruction in personal habits, and (4) instruction in industrial work. In most cases all four factors probably contributed in varying degrees toward the result.

The higher scores received in the retest were not entirely unexpected in view of the very tangible evidences of improvement that many of the girls had shown in various ways. Fourteen girls who had been illiterate upon admission, in spite of having spent from five to ten years in school, had, during the four years between the two tests, learned to read and write, most of them sufficiently well to derive real pleasure from the reading of books and the writing of letters to friends and relatives. One girl, the idiot already referred to, whose vocabulary, when she was admitted, consisted of seven intelligible words, had used over three hundred at the end of the four years. Ten girls who could neither dress themselves nor care for their personal needs at the time of their admission to the Village, at the end of the four years had been taught to do both without any assistance. These girls all have a mental age below 7 years and would be supposed incapable of tying bows, but they have all been trained to tie the bows of hair ribbons and shoe laces. In nine of these cases the retest showed a gain of from one to four

years in performance ability; in one, there was no change in score although she had apparently improved as much as the others.

In addition to the intelligence tests, personality studies of the girls were made both in 1920 and 1924, but the second set were so modified and expanded that their results are not comparable with those of the first. Sufficient data have been obtained, however, "to show that personalities of various types influence, either favorably or adversely, the academic, vocational, and moral (used in the broad sense) learning processes; also that, within limits, personality itself can be modified by education and training".

The conclusion to be drawn from the results of the retests is that "many mental defectives who enter institutions as adults have not been trained to the full limit of their mental capacity or their performance ability prior to admission. This accounts for many of the gains made in the reëxamination of these individuals. Because of this fact, it is probable that the original tests did not measure the true mental levels nor the full extent of the performance ability in these cases; the second tests seem to be truer indices of their actual intelligence. A comparison between the results of the two sets of tests shows clearly that many of these women who, for various reasons, have not received either sufficient education or proper training prior to their admission to the Village, have profited both academically and industrially by further education and training carefully directed and scientifically applied."

BOOK REVIEWS

MENTAL DISORDER AND THE CRIMINAL LAW; A STUDY IN MEDICO-LEGAL JURISPRUDENCE. By S. Sheldon Glueck. (Criminal Science Monograph Series, published under the auspices of the American Institute of Criminal Law and Criminology.) Boston: Little, Brown, and Company, 1925. 693 p.

The essence of this book is its well-rounded and well-supported program for the improvement of legal and judicial procedures in dealing with insane persons accused of crime. The program that the author presents is thoroughly practical. It might be applied in any state within a few months if a legislative assembly would enact the necessary bills. No reputable authority supports the system of hypothetical questions and expert witnesses that it would supplant. No other book published in the English language presents such a program in an equally clear and valid manner.

The entire book is organized with reference to this program. A history and description of existing procedures is presented, but the account is sufficiently general to add to rather than detract from the development of the program of policies. The various types of mental disorders and the legal significance of each are described in a concise manner, and this description does not demand a detailed knowledge of psychiatry to be appreciated. The book is, in fact, an attempt at a cross-fertilization of cultures, a combination of the knowledge, viewpoints, and interpretations of the judges, lawyers, and lawmakers, on one side, with the knowledge, viewpoints, and interpretations of the psychologists, psychiatrists, and social workers on the other side. The author is well fitted for this task, since he has combined both cultures in his own experience, being a member of the bar of the state of New York, a teacher of criminology, and a professor of social ethics. The general thesis of the historical portion of the book is that procedure in dealing with the insane has been gradually modified during the past centuries by the infusion of scientific knowledge and public standards of morality into the courts and legislatures. The author is attempting to adopt this policy as a means of modifying the present procedure, though he attempts to make the policy unified and systematic rather than haphazard, as it has been heretofore.

The general program that the author proposes is as follows: (1) Psychopathic clinics should be attached to the magistrates' courts and should sort out the mentally unsound before trial. A routine exam-

ination of those accused of certain classes of crimes has been established with excellent results in Massachusetts. (2) The Washington plea in cases where insanity is involved should be required. (3) The tests of irresponsibility should emphasize the general understanding of psychiatric principles. Without that understanding no tests can be satisfactory; with that understanding it may be possible to use the "knowledge test" and the "irresistible impulse" test. (4) The expert-testimony bill of the American Institute of Criminal Law and Criminology should be adopted. (5) The use of habeas corpus for those acquitted of crimes on the ground of insanity, but committed to institutions for the insane, should be definitely restricted.

The author specifically discards behavioristic psychology as not suited to deal with the problems of intent, volition, and responsibility, which are the essential psychological concepts in criminal law. He maintains that behavioristic psychology, valuable though it may be in other respects, is fitted only for the primitive law which regarded the external act, but took no account of intent. The author's argument here, as elsewhere, is doubtless determined by his program of immediate policies. A program that raises questions regarding fundamental concepts cannot be put into practice within a few months. But in the long run and from the standpoint of a distant program, there is no sufficient reason at present for outsiders to commit themselves as either in favor of or opposed to behavioristic psychology. A behavioristic psychology appears to be valid in law if it is valid anywhere. The only method that can be used in determining intent, volition, and responsibility in court is by testimony regarding *behavior*. The translation of this evidence into terms of psychic essences causes much difficulty and confusion. Certainly the facts of behavior that have been focused through these psychic concepts need to be taken into account, but the facts of behavior can be taken into account without utilizing the psychic concepts. They are thus taken into account at present in the juvenile court. And the author, in fact, while openly rejecting behavioristic psychology, surreptitiously utilizes it when he defines responsibility in terms of educability. Educability can be determined only by behavior and requires no translation into terms of psychic processes. Moreover, educability puts the emphasis on future behavior rather than on an assumed state of mind at the time the crime was committed.

An appendix of about one hundred and fifty pages gives a valuable compilation of the laws of the various states with reference to tests of irresponsibility, the method of proof of insanity in accordance with these tests, and administrative and procedural policies.

University of Illinois. E. H. Sutherland.

NERVOUS AND MENTAL DISORDERS FROM BIRTH THROUGH ADOLESCENCE. By B. Sachs, M.D., and Louis Hausman, M.D. New York: Paul B. Hoeber, 1926. 861 p.

During the past twenty years much light has been thrown on the dark places of neurology, both from the clinical and the experimental standpoint; the whole field of the extra-pyramidal disorders has opened up and the infectious diseases that involve the central nervous system have been the subject of intensive investigation by modern methods. It is, therefore, natural that Dr. Sachs should have felt that the second edition of his book *The Nervous Diseases of Children,* published in 1905, no longer did justice to the present body of knowledge dealing with nervous diseases and should have been induced to present the results of his mature experience in this field in the present volume. The present book is no mere revision of his previous book; it is practically a new book, in the production of which he has been assisted by Dr. Louis Hausman, who has especially taken the responsibility for the chapters dealing with the anatomy of the central nervous system and with methods of examination, as well as for the preparation of the bibliographies which add so much value to each chapter.

After the first part, devoted to anatomical considerations and methods of examination, the main organic diseases of the nervous system, the functional and toxic diseases, and the endocrine disorders, including a variety of somewhat obscure conditions, are discussed in the three following divisions of the book. The presentation of each of these subjects is clear and concise and bears the imprint of the wide clinical experience of the senior author.

The fifth part of the book is that which is most likely to interest the reader of MENTAL HYGIENE; it is devoted to mental conditions and contains five chapters. The chapter on the neuroses and psychoneuroses covers a large field in a rather general way and the absence of illustrative clinical material may make it somewhat difficult for the reader to get a clear idea of the various types of reaction which are met with in actual practice, or a firm grasp of the actual mechanisms of these disorders. The author puts neurasthenia as deserving first mention among the disorders included in this chapter. It is doubtful whether neurasthenia is a useful conception, and no clear clinical picture is presented of the condition. One can hardly agree with the author that such physical signs as tremor and an increase of the deep reflexes make a very concrete clinical picture out of the rather elusive group of symptoms that he describes. The reader may find himself also somewhat at sea in trying to get a clear idea of the type of boy

or girl who is referred to as psychasthenic "and who is popularly stamped as a crank".

So in the chapter on hysteria, some of the terminology used and of the views expressed smack of rather formal considerations and of an earlier mode of approach. Much emphasis is laid upon hysterical hemianæsthesia, but the fact that this hemianæsthesia is probably due to the mode of examination or to suggestion from other factors in the environment is not specially stressed.

The chapter on insanity deals especially with conditions referred to as dementia praecox and manic-depressive insanity and gives a clear, if somewhat schematic, presentation of the various forms of these disorders as formulated by the Kraepelinian school.

In the chapter on idiocy and imbecility, the authors have paid little attention to the more recent classification of forms or degrees of mental defect and repeat the classification used by Sachs in his former publications. They group together idiocy and imbecility and use the terms idiocy and feeblemindedness rather indiscriminately. No reference is made to the standardization of terms by the British Royal Commission on the Care and Control of the Feebleminded in 1908 or to the later one of the American Association for the Study of the Feebleminded. The psychometric scale offered on pages 815 to 817 suggests that this chapter has been rather hastily and uncritically written. The chapter would probably have been of much greater value if less attention had been devoted to the severe degrees of mental defect and more to the milder degrees and the disorders of conduct and difficulties of management associated with the latter, and to the principles of treatment which should guide the physician in these matters.

These four chapters give the reader a good idea of the standpoint from which the authors survey the problems of childhood and the extent to which they retain conservative formulations and attitudes. It is, therefore, to be expected that in the special chapter devoted by the senior author to the development and training of the normal child, there should be a strongly conservative note. To the senior author the past appears as "the good old days", and the methods of education in nursery and in school of the good old days strongly appeal to him, while modern educational methods are looked on with some suspicion and are liable to be treated as fads, and anything connected with the psychoanalytic school of psychopathology is anathema. The estimate of this chapter will depend very largely upon the prepossessions of the reader, who may read it with marked approval or with the opposite according to the direction in which his sympathies lie. Naturally in the setting of this book the author has not the space

for detailed argumentation or discussion of clinical material, and the chapter is to be looked upon as presenting his own personal creed. This creed is expressed in a clear and vigorous way. It emphasizes what is of value in the age-long tradition of education, it puts forward what the author considers to be the proper duty of parent and teacher to the child, and it stresses the necessity for effort, discipline, and for suffering. From the point of view of treatment there is constant reference to the value of common sense and of a parent, teacher, or nurse with the right personality. In the part of this chapter devoted to the evils of psychoanalysis, the author does not strictly differentiate between the sin and the sinner, between the disturbing influence of certain psychopathological doctrines and the personal influence of those who happen to apply these doctrines and who may not have that common sense on which Dr. Sachs would place so much emphasis. The very fact that a chapter of this type has been introduced into the book shows how much progress has been made since the publication of the last edition of Dr. Sachs' treatise on the nervous diseases of children, and perhaps part of this progress has been due to the stimulating influence of those to whose doctrines the senior author takes so much exception.

The book is well arranged, clearly printed, fully illustrated, and is a very welcome book of reference.

C. Macfie Campbell.

Boston Psychopathic Hospital.

A Practical Psychology of Babyhood: The Mental Development and Mental Hygiene of the First Two Years of Life. By Jessie Chase Fenton. Boston: Houghton Mifflin Company, 1925. 348 p.

Books that treat the developmental possibilities and problems of happy, healthy children are all too few. Here is one that does this in a clear and thorough fashion. Written by a mother familiar with the trivial-seeming details that count so much in the life of the little human being just getting acquainted with the world about him, it will be a real help to parents in their difficult task of learning when to stand aside and let their children forge ahead by themselves and when to encourage certain interests and tendencies in order that others may be crowded out. Only the keener-minded or better-trained mothers and fathers are likely to be tempted to read so complete a treatment of any serious subject, but, unaided, even parents of this type are far from being able to give their children a fair start in life. Alert young men and women fresh from college psychology classes find themselves hopelessly at sea when confronted with the necessity

of untangling the mental drives of their own tiny children. The more thoughtful these parents are, the more perplexed do they become as they watch the personalities of their little ones develop. By the time the children reach the end of the second year, their mothers and fathers are often desperately seeking assistance from books and interviews with skilled advisers on behavior difficulties. Since the beginnings of behavior patterns are constantly being traced during the first two years, it is an advantage to be prepared for the problems that most frequently arise in the care of ordinary children of this age, so that conduct knots may be prevented or untied before they are interwoven with so many subsequent associations as to be hard to straighten out.

With a delightfully personal touch, the author exemplifies the principles of child psychology by recounting incidents in her own small son's development, giving always enough theoretical background so that the reader unversed in psychology will see the significance of the situations portrayed. A fascinating survey of the growth of a baby's ability to control himself and his environment gives one the means of gaining insight into the why of little folks' doings so that one may have an understanding of the causes and values of babyhood reactions and therefore be in a position to determine for oneself what constitutes wise guidance of infantile strivings. Concrete suggestions as to how one may substitute a desirable for an undesirable activity or emotion make clear the actual working of the mechanisms of forming and discarding habits; the development of complexes and their reinforcement, removal, and prevention are deftly treated in a brief, yet practical way; and the line of departure from excessive feelings of anger, fear, jealousy, and the like is plainly pointed out, so that the injunctions, "Avoid fear", "Do not block anger", are brought within the power of attainment of the conscientious parent. The so-called cruelty of children in its normal aspects is touched upon in such a way that its cause and cure become simple matters, instead of the bogy they are felt to be by many parents. The avoidance of unnecessary friction in the life of the child is given the emphasis it deserves and is brought within the bounds of possibility by a vivid portrayal of typical methods of winning easy compliance with irksome, but necessary restrictions. The danger of overdependence of the child on its mother is stressed and the best manner of giving opportunity for self-reliance to develop is pointed out. Vigorous intellectual growth is related to the feeding of curiosity and the safeguarding of the childish zest for life, so easily quenched by adult ridicule or indifference.

One is surprised to find the assertion, "Intelligence is now definitely

known to be a hereditary trait, like the color of hair or eyes, general shape of features, or other qualities which run in families'', supported by a citation of the Edwards-Tuttle, Jukes, and Kallikak studies, and the equally unfounded statement, ''It has further been established beyond doubt that the growth of mind is a regular one, keeping always at the same relative distance from the average. . . . The dull child becomes the dull man; the bright child grows into the adult of superior ability; the wonder child in later life becomes the genius.''

Except for these dogmatisms and a resultant tendency to advocate undue haste in bringing to the child opportunities for enlarging his experience, lest he fail to achieve the maximum intellectual growth made possible by his inheritance, the book is certain to have a most wholesome influence on its readers. It can be advantageously used by study groups of parents and by child-psychology classes. Few parents will read it without profit and fortunately many will be led by their interest in the development of their first-born baby to study the book before their need of such help as it offers has become painfully acute.

Gladys Hoagland Groves.

Needham, Massachusetts.

Concerning Parents: A Symposium on Present-Day Parenthood. New York: Republic Publishing Company, 1926. 284 p.

This reprint of the addresses at the National Parenthood Conference last fall is having a deservedly wide circulation. For the most part direct and popular in form, it makes stimulating reading well within the scope of busy parents, who will find that its short chapters sandwich in conveniently between the rush periods of a crowded schedule, or, if they prefer to read the volume through in a day, will be surprised to see how easily it can be done. In either case, they will be impelled to look critically at some points of their own habitual procedure with their children and to reëstimate in a new light the interrelations of their family unit with the larger groups of which it is a part.

The book will appeal quite as much to fathers as to mothers, for it evaluates the obligations and risks of the family from a detached point of view in the interest of society at large as well as of the welfare of each individual immediately involved.

Of the more than a score of discussions by scholars and workers concerned with different aspects of personality direction, all save three or four are pertinent and in one way or another make clearer the whole business of parents. The fundamental cravings of children at various ages are uncovered and their practical bearings for the individual and for society are made plain. The mistreatment that

children have to put up with even from intelligent and affectionate parents is sketched in sharp outlines and the reasonable handling of young folk is pictured by more than one experienced and thoughtful worker with them. Discussion of the meaning of childish restlessness and the danger of youthful "good" behavior prepares the reader for interpretations of adolescent conflict and suggestions as to the part parents should play in this time of stress for their fledglings. The implications of leisure, recreation, education, and religion from the viewpoint of parent and child are studied, as well as the personal and family rights and duties of fathers and mothers, with the conclusion that breadth of interests makes for more wholesome mothers and that fathers need to share with mothers to a greater extent the guidance of their children, since too much mother is as bad as too little father for the young of the family. Finally the actual and possible service of the community to the family and of the family to outside life are considered.

That so many workers and thinkers in varied fields are seriously attempting to put something of the findings of science within the reach of the ordinary parent is doubly encouraging, especially when coupled with the fact that so many parents show themselves eager for this guidance.

Gladys Hoagland Groves.

Needham, Massachusetts.

Psychoanalysis and Æsthetics. By Charles Baudouin. Translated from the French by Eden and Cedar Paul. New York: Dodd, Mead, and Company, 1924. 328 p.

This volume, the general tone of which creates the impression that it was designed mainly for popular consumption, possesses, it seems to us, the features typical of such psychoanalytic works. Books of this class are usually signalized by comprehensive titles scarcely warranted by the limited scope of their contents. Next, a laudatory preface never fails to advise the reader that Freud's achievements have been, if not surpassed, at least equalled. The body of such texts, generally couched in a loose and inaccurate terminology, regularly contains serious misconstructions of fundamental Freudian concepts. Sexuality, of course, must be relegated to the background, lest the reader be offended or perhaps frightened. Finally, the author of your popular treatise rarely omits, by way of conclusion, to survey his work and to find it very good indeed.

The title of Baudouin's book is decidedly intriguing, but the contents are disappointing. The translators devote the greater part of their preface to an affirmation of Baudouin's rare qualifications for

authorship and to a proclamation of the unusual merits of his book. The reader is told in no uncertain terms that "the 'interpretation' Freud has supplied for dreams, Baudouin achieves for the imagery of the artistic creator". We regret that we cannot concur. We fail to see in *Psychoanalysis and Æsthetics* anything more than an attempt —and, in our opinion, a not very successful attempt—to elucidate psychoanalytically the poetic symbolism of Emile Verhaeren.

In an introduction, some thirty-four pages in length, the author discusses the general aspects of symbolism. As we read through his introduction, we gradually sense the peculiar tone of the book. We become aware, on the one hand, of an inclination to apply Freudian formulations, and, on the other hand, of an unwillingness to accept them. This spirit of ambivalence pervades the whole book and affords some curious contrasts. On page 24, for example, the author suggests minimizing the rôle of the sexual in repression, evidently hoping, as the context implies, to mollify the resistances of his readers—"we shall make our ideas more digestible . . ." But on page 111 he apparently advocates a frank recognition of sexual factors. On page 32 the existence of "dissident sects" (psychoanalytic) is noted; yet Freudian and post-Freudian (Jungian, Adlerian) terms and viewpoints stroll hand in hand through the pages as if they were quite compatible, reconcilable, and interchangeable. On page 205 the Freudian implications of the Œdipus complex are discussed, only to have their significance so toned down that, on page 206, the reader is told to elect some other explanation, should he find the Freudian one unacceptable. The choice seems to be left a matter of personal taste. That the author's concern about the emotional reaction of his public is partly a projection can be learned from page 20. Here, although he deprecates the attitude of many French scientists toward Freud, he proceeds to invoke that famous bogy—the danger of psychoanalysis—and to tremble lest scientific method perish at its hands. In addition, the frequent appearance of technical psychoanalytic terms in quotation marks lends an *as if* quality to this work.

Baudouin attempts to approach the problem of Verhaeren's symbolism by using Ribot's concepts of condensation and transference as points of departure. Within a very few pages he summons Freudian formulations to his assistance, and it is essentially from this angle that he proceeds. But soon compromises with the Freudian notion of the symbol creep in. On page 27 we are told that "the symbol is *often* the expression of the subject's unconscious". (Reviewer's italics.) Soon (page 28) the symbol becomes a poetical comparison, an emblem. On page 226 a distinction between "a stock metaphor, a mere comparison" and a symbol is apparently accepted, but this is

entirely nullified by the view expressed on page 298: "The diversity of metaphors prevents the symbol from becoming an allegory." This shifting of position must be very confusing to the lay reader.

Now there are, to be sure, a number of forms of figurative representation (allegory, emblem, metaphor, sign, simile, symbol, and so forth). But psychoanalysis asserts that the symbol is an unique form of comparison, generally distinguished from all other types by unmistakable characteristics. It is unnecessary either to describe these features or to offer a justification of this differentiation here. Those interested are referred to *"Die Bedeutung der Psychoanalyse für die Geisteswissenchaften"* by Rank and Sachs and to Ernest Jones' *The Theory of Symbolism* in which the validity of this contention has been ably demonstrated. Baudouin's bibliography, incidentally, contains no reference to these two essays. It is sufficient for the purpose of this review to point out that symbolism in the Freudian sense involves an unconscious comparison. The so-called symbols described by Baudouin are all too frequently comparisons on a foreconscious level. Thus (page 264) "gold . . . symbolizes life in all its wealth and fruitfulness". This is a typical application of the symbol concept in a non-Freudian sense.

In a short final chapter, the author announces (page 294): "We are now ready to outline a psychology of art." He evidently feels (page 295) that he has penetrated "into the most intimate recesses of Verhaeren's soul". It seems to us that he has, too frequently, contented himself with an exposition of the more superficial foreconscious aspects of the interesting material at his disposal, and so has failed to reveal much of its deepest unconscious significance. Hence he is scarcely in a position to amplify what psychoanalysis has already contributed to the understanding of artistic striving and æsthetic feeling. His own opinion of his book appears on page 307: "We claim no merit for having brought our analysis to so satisfactory a conclusion."

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Our Enemy the Child. By Agnes de Lima. New York: Republic Publishing Company, 1925. 288 p.

The title of this book is most suggestive; there is literally no end to the discussion that might be offered upon it and it would well-nigh cover the field of mental hygiene. From the time of conception until he is grown, the child thwarts the plans and ambitions of those who are responsible for him, and so produces the problems with which everyday life has to deal. The writer, however, confines herself to

the educational phase of the problem, and her book is a useful summarization of present-day educational systems. It is most readable and interesting. There is a manifest effort to give a fair and impartial account of each plan described and to note points that have been open to criticism.

The book seems to suffer somewhat from the lack of first-hand experience on the part of the writer in regard to some of the subjects discussed. In the chapter on mental testing, she seems to go beyond her depth. This chapter is not well organized and it is logically unsound. Such conclusions as are finally reached owe whatever validity they possess to their independence of the faulty premises. Criticisms of the platoon system are *a priori* rather than the result of experience. The writer fails to point out the hopeless confusion of the little child who is shifted from teacher to teacher.

Further experience with the individual instruction plans will no doubt force the realization that the child who must be poked and prodded along the way of the three R's in order to be promoted must be urged even harder to reach the standard of perfection in one task necessary to earn the right to attempt the next harder task of the series. However, the author correctly concludes that experience with these plans will doubtless lead to modifications that will tend to meet the *a priori* objections she does cite, and this conclusion may well be applied to the weakness of the method which she fails to point out.

A more fundamental error is perhaps the failure to see that results such as are obtained by a method in the hands of highly selected teachers, working under exceptional conditions, can hardly be expected to follow the use of the same plan in the hands of the rank and file of overworked, bored, uninspired teachers, working to meet the demands of supervisors of the same type who in turn are trying to satisfy administrators who are concerned more with the job of building up a strong organization than with the education of individuals.

Finally, to a non-New Yorker, parts of the book appear a bit provincial. The faults of intelligence tests are, one finds, the faults of the specific intelligence tests used in New York schools. Labor and the new educational movements mean labor and the new educational movements in New York. In spite of these few points which appear open to criticism, the little book is making a timely appearance and should be of inestimable value in mothers' clubs and teachers' study groups. The child must be liberated.

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SAFEGUARDING CHILDREN'S NERVES; A HANDBOOK OF MENTAL HYGIENE. By James J. Walsh, M.D., and John A. Foote, M.D. Philadelphia: J. B. Lippincott Company, 1924. 272 p.

This book contains a valuable collection of practical and helpful suggestions with regard to the mental health of childhood. In putting it together, the writers have ever had in mind the common and perplexing inquiries of parents which daily confront the family doctor, the pediatrician, and the health worker. These inquiries are treated specifically in such chapters as: (II) *The Nervous Child;* (III) *The Spoiled Child;* (IV) *Misunderstood and Different Children;* (V) *The Bogy of Heredity;* (VI) *Vital Foods and the Nervous System;* (VII) *Nursing and the Nurse;* (VIII) *Rest and Fatigue;* (IX) *Recreation in Theory and in Practice;* (X) *Discipline and the Nervous Child;* (XI) *Nerves and the Sick Child;* (XII) *Habits, Good and Bad;* (XIII) *Some Abnormal Habits of Childhood;* (XIV) *Habit Spasms —Tics;* (XV) *How Dreads and Dislikes are Formed;* (XVI) *Backward Children.*

The chapters are short, but compact with facts rather than theories. The data is presented in a readable, story-telling manner that is simple enough for the average mother and busy physician to grasp easily and remember with interest. To the more initiated also this book has a strong appeal in that its contents are based on a firm scientific foundation. For example, in the chapter entitled *The Bogy of Heredity,* one finds an adequate and substantial presentation of the contributions of Darwin and Mendel compared with the most recent work of Conklin. The deductions are well illustrated from practical examples of human experiments with nature in the past and present. The influence of environment is not slighted, and the reader is left to draw his conclusions from facts rather than from the prejudiced opinion of any one point of view. The topics of rest, nutrition, and play reactions are sanely covered without the usual pediatrician's overemphasis on such matters as panaceas for all nervous manifestations of childhood. Accompanying the biological hygiene of early childhood is a careful and intelligent discussion of its psycho-biological aspects. Again, one finds a well-balanced combination of medical and psychological understanding. For example, "the nerves" of childhood are not considered solely as the functioning of little white strings that come down from the brain; neither is one forced to consider them through the complex medium of "cell memories" and "refinements of standardization". The behavior of childhood is treated quite simply as a functioning of the individual as a whole. Habit formation, early guidance in training, environmental influence on the emotional life are frankly reviewed with con-

crete suggestions as to management of the many problems of infancy and early childhood that arise from these sources.

While this book makes no attempt to deal with the specific deviations found in atypical children, it does not ignore their existence. In dealing with the backward and defective child, the authors call attention to the necessity of early recognition of special training without becoming involved in the intricacies of educational methods which are not within their province.

Safeguarding Children's Nerves would undoubtedly make a better appearance without the pictorial illustrations borrowed from the American Child Health Association. These illustrations, while excellent as poster material, for which purpose they were designed, detract from the dignity of the book. A bibliography would also enhance its value as a standard contribution to the literature of mental hygiene.

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Pratique Sémiologique des Maladies Mentales. By Paul Sollier and Paul Courbon. Paris: Masson et Cie, 1924. 457 p.

If one is looking for a presentation of psychiatry from the dynamic standpoint, or with a Freudian flavor, one will be disappointed in the work of Sollier and Courbon, nor will one find much discussion of the newer ideas expressed by Bleuler or Kretschmer. In fact, the authors are a little out of sympathy with a tendency to create a new nomenclature, saying, "*La manie du néologisme semble avoir passé du camp des aliénés dans celui des aliénistes.*"

The whole work seems to have national limits, the authors being quite satisfied with the standard French conceptions. It has, however, a number of distinct merits which are sufficient to recommend it for perusal and study by all who are interested in psychiatry.

The plan of exposition, as indicated in the title, is what the French would call the semiological—that is, the presentation of the symptoms with the discussion of these symptoms and the conditions in which they are most likely to be found. In the preface the authors state that the book is addressed to practitioners and students of medicine rather than to psychiatrists. In their presentation they attempt to "follow the logical order of the clinic"—that is, to outline the examination of the patient, including all the systems of the body, physical and mental, as well as the history.

The value of the work—and the reviewer believes it is a distinct and important value—consists in the careful description of clinical symptomatology, all written in a simple, easily understood, and concise style. The description of various symptom complexes can be

read with great gain. Thus, the authors divide their depressions into the following classes: simple melancholia, delusional melancholia, anxious melancholia, melancholia with stupor, religious melancholia, melancholia with ideas of persecution, and hypochondriacal type of melancholia. Under each of these headings one will find clean-cut descriptions of the syndrome, which cannot but make one observe one's own cases with more clarity. Such descriptions also tend to make one less well satisfied with a few diagnostic pigeonholes. One is reminded of how many differences and kinds there may be of depressions, excitements, paranoidal reactions, and the like.

For the teacher and for the student, the book is a storehouse of neat definitions, all couched in simple language, practically all being given in French terms rather than in hybrid Greek, Latin, or German, and easily translatable into simple Anglo-Saxon terms.

Descriptions of mystical ideas of different varieties—such as pure mysticism, mystical delusions of a melancholic variety, mystical delusions of a persecutory form, delusions of spiritualistic or mystical type—with discussion of these ideas occurring in states of mental confusion or weakness, are rather interesting variations from the usual description of these matters as merely delusional.

In dealing with ideas of grandeur, the authors call attention to the possible division into true grandiose ideas, ideas of power, force, with or without euphoria or exalted mood; ideas of pride and ambition; and ideas of infinity, of eternity, of immortality, of immensity. Descriptions of the various types of obsessions, impulsions, fears, and the like, are all clearly portrayed.

In general, one comes away from reading the book feeling that one's ideas of descriptive psychiatry have been greatly enlarged, that one is able to formulate ideas and to describe symptoms and syndromes more clearly. One can define one's meaning better. The reviewer feels that a few hours given to study of this work will be well repaid.

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A Psychological Study of Immigrant Children at Ellis Island. By Bertha M. Boody. Baltimore: Williams and Wilkins Company, 1926. 163 p.

A thoroughly adequate review of this study would require the attention of a person who combined in one many human services and interests, with a fund of sound, widely ranging information. Coming to the book with the somewhat unavoidable viewpoint of the clinical psychologist, one early reaches the conclusion that the one thing not obtainable under present conditions is definite facts with regard to the

mentality of the many nationalities streaming into the country, since they are impossible to secure in a short time in the stress of a busy immigration station. The necessity for helping these wayfarers to reach a destination, settle a home, join a relative, as quickly as the law allows, rightly overshadows even the most intelligent desire to know more exactly the mental equipment of our future citizens. Nevertheless, with a fine, frank understanding and expression of the limitations of such a study, it was undertaken as a suggestion, if not a finality.

The immigrant group presents, first, a selection from the country of birth and, second, a selection by the United States of those permitted to enter—the latter restricted as to quantity and quality, stipulated by law and operating under the physical and emotional conditions peculiar to an immigrant station. These conditions are admirably described and their possible influences recognized in a way most heartening to those who watch, rather despairingly, reports of psychological studies that are only a series of psychometrics with no psychology in them.

The first five chapters of the book concern themselves with a recapitulation of previous important investigations of the mentality of the immigrant, a review of the laws on immigration with their observable results, and an extremely careful description of the procedure at Ellis Island, with an interpretation of certain steps and devices in the procedure as well as its effects on the emotions and attitudes of the immigrant group.

Given this background, the reader enters upon chapter six, which describes the study proper. This was undertaken during two successive summers. The period of August and September, 1922, was partly a preliminary tryout, but included also a survey of a very young group, ranging from four to nine years of age. The older group, from eight to sixteen years of age, was studied in July and August of 1923. In each group approximately twenty-five nationalities were represented, but the individuals in each nationality group varied from day to day, owing to the departures and new entries. Naturally, the conditions of the study were not scientifically controlled, as the routine of the Island had to be strictly maintained. Therefore, the proportion of any nationality to the whole group varied, the proportion of boys to girls was not constant, neither was the age range fixed or the total number of individuals in the group from day to day.

Admitting the inconclusiveness of the study under discussion, there seems no good reason why a more prolonged investigation should not be undertaken, provided the authorities are convinced of its value. As one often has to find substitutive methods, the impossibility of an

intensive period of work under constant conditions indicates the feasibility of an extended study which would in the long run equalize the nationality groups in number, sex, and age distribution.

The older group, studied in 1923, was taken from the school maintained on the Island for the benefit of the detention group, but, as the attendance is voluntary, the older group is a selected representation of the detention group. Furthermore, some nationalities, as the German, Hebrew, and Polish, were evidently detained in greater numbers than others; some nationalities had very few children in the immigrant group as a whole—the Scandinavian, for instance; and the very fact that it was a detention group is a selective factor. Exactly how this selection operates is not definitely known, as people are detained for many reasons—sanitary, financial, legal, and diplomatic.

The tests used had to be non-language, and note that that means non-language directions as well as performance. The individual tests chosen were non-language material from the Binet-Simon scale, others from the Merrill-Palmer scale of Mrs. Woolley, and an original color-, form-, and size-discrimination test. In addition, the Army Beta was given to 251 children in small groups under regular army-test procedure.

The results of each test were listed under nationality, sex, and age factors; the general, though tentative, conclusion seems to be that one differentiates, by these tests, among individuals, not races or nationalities, and that selection of immigrants ought to be on that basis. Psychologists and economists have been saying that for years, of course, but it is stimulating and forceful to have it said again with all our war and post-war testing experience behind us and the racial myths slowly dying out.

The seventh chapter is devoted to a review of the immigration law of 1924, with a forward-looking note as to its application and probable results.

If any thought is given to the problem at all, many questions arise as to the methods, validity, and reliability of the testing procedure as a selective measure. Actually, it is guesswork—though very intelligent guesswork—which has set the standards for entrance. The question is not what is the status of the average immigrant, but what, at the time of entry, was the status of our present-day successful foreign-born citizen? And that is precisely the question it is impossible to answer because of the difficulty in reaching the immigrant group once it has disbanded and spread through the country. The practical alternative has been to set a standard low in comparison with American norms, with the realization that there will be improvement of unknown amount after social and emotional adjustments have been

made, and, in addition, after regular attendance at school has been instituted for the children.

The situation in the European countries varies so widely that, even under the unfavorable testing conditions at Ellis Island, the influence of schooling is seen in the tests of Scotch, Finnish, and Welsh children, as compared to the unschooled country children of South Wales. What do we know of the respective amounts of improvement to be expected from their American training experiences? Ought the standard of entry for each nationality, then, to be the same? Or ought the standards to differ according to educational and occupational opportunities, regardless of nationality? The results of the 251 Beta scores compared with the scores of a "recently landed" group tested by the author in a Baltimore school show that 105 of the immigrating group fell below the average of the latter group. The influence of schooling and social adjustment is obvious, as Dr. Boody points out, but in addition one would want to know how representative the detained group is of the whole group, how many of the 251 were finally admitted, how many deported, and why.

Another serious question is how much mental instability among the foreign born could be avoided by increased attention to the immigrant problem, not only from the economic and social, but also from the mental-hygiene, point of view. Institutional reports quoted in this book show the large number of *recently* landed immigrants hospitalized for mental disturbances.

It seems worth while to devote considerable time and to expend considerable energy in an official experimental attempt to avert the onset of preventable emotional disturbances, as well as to increase our ability to detect the unpreventable. It would be valuable to have the reaction of psychiatrists and of social workers affiliated with organizations that deal particularly with immigrant groups to the possibility, practicability, and value of such a program.

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G. STANLEY HALL: A BIOGRAPHY OF A MIND. By Lorine Pruette. New York: D. Appleton and Company, 1926. 267 p.

Dr. Pruette's book may well set a new style in the writing of biography, provided other biographers have sufficient blending of scientific attainment and literary talent to follow her example. The titular claim that this is "a biography of a mind" is a modest one; actually, it is a study of personality and character development. The results of Dr. Pruette's analysis are presented without that tedious detail which has encumbered many biographies written in the psy-

choanalytic vein. Just as she has swept aside chronological irrelevancies, collecting them into a few pages as a sort of appendix for the more literal-minded reader, so she has been wise enough, also, to assume that her analytical methodology will be understood without the necessity of describing it. The product is a story of G. Stanley Hall which centers constantly around that fascinating figure, without excursions into other fields that have only an indirect relation to it.

An essential feature of Dr. Pruette's book is that through all the pages the picture of Stanley Hall stands out well-defined and complete. We do not glimpse the man in parts, which we must put together laboriously in order to have some conception of the whole. Even when we are seeing first one side of his personality and then another, in relation to the factors that molded it, we are always conscious that this is only one aspect of the man, and we are prepared to have the scene change and show us another side of his nature without any sense of abruptness. It is this ability to understand him, and make us understand him, too, without destroying the feeling of completeness, that is Dr. Pruette's finest achievement. Reading her book is much like sitting through a successive series of those famous seminars which she describes, where Dr. Hall would present one mood on a certain evening and the next an entirely different mood—changes that we recognized as signs of the rich complexity of his mental life, knowing that behind these surface alterations his kindliness and interest in the welfare of his students was constant and unchanging, though a lesser spirit than his might often have been troubled with the homely thought that he was casting pearls before the unappreciative.

Besides being a fitting tribute to a great man and a welcome addition to biographical literature, Dr. Pruette's book is also a contribution to psychology and mental hygiene. Biography very often furnishes data for the better understanding of the psychology of the individual; this one goes beyond that, and also points to the lessons in mental hygiene which accrue from Hall's own applications of his psychological knowledge to his problems of mental adjustment. His appreciation of the Puritan strain within his make-up, and his conscious adoption of paganism to balance it; his attempts to make an objective and scientific study of his personal problems rather than to nurse his peculiarities until they became hampering temperamental traits—if these were the only illustrations of mental-hygiene principles in the book, it would be worth reading by all students of this subject. But his whole life was rich in similar trends; some of these Dr. Pruette definitely indicates, others she leaves for the reader to deduce for himself. Whatever else may be said of Hall, as the years pass, he will

certainly not lose the reputation of being one of the greatest mental hygienists among educators. He saw his own deficiencies and tried to shape his acts to overcome them; he saw the ills of contemporary education and tried to correct those; he had the rare gift of sympathy and insight for his students and tried to help them to become better mental hygienists for themselves. In this, at least, all educators might learn a great deal from Dr. Pruette's biographical sketch of Hall.

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MONGREL VIRGINIANS; THE WIN TRIBE. By Arthur H. Estabrook and Ivan E. McDougle. Baltimore: Williams and Wilkins Company, 1926. 205 p.

While the first word of the title of this book—"mongrel"—may be scientifically applied to the results of interbreeding between human races, its implication, on the whole, derived as it is from the breeding of dogs, is unfortunate and rather offensive. Its usual association in the average mind with an inferior and no-account dog makes its use in an ostensibly scientific publication prejudicial to a dispassionate consideration of the subject. This, of course, is a matter of no great importance except that it makes a bad beginning for a book that asks for scientific consideration.

The book deals with the social, cultural, and mental traits of a group of between 500 and 600 individuals living in the foothills of the Blue Ridge Mountains in Ab County, Virginia, and representing an intermixture mainly of white and Indian, but also of Negro. "One mission school of a church has furnished practically the only education offered to these folks. . . . The one dirt road which cuts the area into halves becomes impassable in winter except by horseback. . . . The white folks look down upon them, as do the Negroes, and this, with their dark skin color, has caused a segregation from the general community. . . . They live generally in log houses or rough shacks. . . . They are mostly renters on the land. . . . Their main source of income is from tobacco raising on shares."

There then follows an account of the various individuals of the group, dividing them into the descendants of various individuals, some of whom date back to the latter part of the eighteenth century. The information upon which the account is based apparently was secured mainly from the people of the church settlement and from the rather prejudiced people of the community surrounding them. Statements like the following appear all the way through the book: "She has no characteristics of an Indian whatever and gives the

appearance of 'a mean white woman with a little Negro in her.'" "He was a typical Indian in physical traits and always worked hard as a renter, later acquiring a little land; 'never amounted to anything and was no 'count.'" (It is hard to reconcile the first part of this statement with the last.) Further, "He was very ignorant and not bright intellectually." (He had no schooling whatsoever.) Of a man born in 1837, they make the statement, "He was uneducated and not particularly bright mentally." (On what basis of information?) "Ichabod Ross, a brother of Levan, has much the appearance of a 'darky with thick lips', and is generally repulsive looking. He is industrious, a bully, and disliked by many." Frequently the following statement is made of an individual, "He had no schooling, and never learned to read and write." It would be rather miraculous if, under the circumstances, such an individual did learn to read and write.

Some idea of the attitude of one of the informants may be gathered from this statement, "She was taken into the home of the pastor of a church in Ab County as a maid and did very acceptable domestic service, but spent her evenings in immoral practices, a fact which would not be believed by the pastor until he became aware of the fact that she was pregnant, *when he forced her to marry the father of the child.* [The italics are my own.] The latter is a white man, aged about forty-five, an ex-soldier with none too savory a reputation." Evidently the judgments passed by such a man on people would be largely based on his religious and moral prejudices. With intermittent and very little schooling, with teaching often of an amateur kind, with time off for doing work in the fields, it is not surprising that what is said of the Wins is true, to wit, "She knows things one day in school; on another knows nothing. This is characteristic of many of the children in school." Most of the characterizations decidedly impress one as being based upon information obtained through gossipy and prejudiced neighbors.

The only psychological tests that seem to have been made were as follows: "The Stanford revision of the Binet-Simon test was given to eleven children during the winter of 1923." The highest mental age secured by any child in this extremely small group was 9.2 years by a child of 11.5 years. The lowest was that of an individual who tested mentally 6.5 when fourteen years old. "Language difficulties did not interfere with the giving of the tests." Just before this the statement is made, "It is difficult to analyze the work of the school at the present time because of the irregularity of attendance on the part of the children. There are children of all ages in the same grade

and there is lack of personnel and equipment to divide the children into groups."

There seems to be a large amount of sexual immorality in this group. Not only are they free with one another, but white men from the neighboring communities come in to help the matter along. Yet one is not impressed with the reliability of the information given to the authors: "A feebleminded boy of twelve with a mental age of 6 told the writers all about the illegitimate children of one of the Win women and who the fathers were." My own acquaintance with boys with a mental age of 6 makes me question very strongly either the authenticity of the information given or the actual mental age of the source of information. Either one or the other is incorrect.

It is interesting to note that "intemperance and drunkenness are not found to any great extent among the Wins". The explanation that "the economic level of the Wins is too low to offer a market for bootleggers from the outside" does not, of course, explain the lack of alcoholism. Very few groups are so low that they do not know how to produce alcohol for themselves.

And marvelous to relate, there is "little or no venereal disease among the Wins". This throws a degree of doubt upon the amount of prostitution amongst them. Studies of prostitutes all over the world show a vast amount of venereal disease. In the records given by the authors, the term, "prostitute", appears in relationship to a great many of the women. This does not mean that prostitution may not occur without venereal disease, but it is decidedly unlikely.

I doubt very much that the statements on tuberculosis which the authors make are worth anything. "The death records of the Wins have been very meager and previous to 1912 no mention is made of the cause of death in the few records that do exist. These few records, with the information from the people, show that sixteen of the Wins are known to have died from tuberculosis and two more probably from the same disease. There are two adults now living known to have the disease and three other suspected cases. These figures are based on general knowledge, not on the results of any regular examinations." If the other facts have no better basis than this, little can be said for the study.

Accepting the book, however, on its face value, it merely reiterates what has been shown many times—that people living in a secluded community, out of the tide of cultural civilization, with no access to schools and a very low economic status, are apt to be primitive in mentality and primitive in morals. *That the study shows anything at all about the results of inter-racial marriages can be definitely denied.* In the first place, the white women who intermarried in the group

were, according to the records, of low order, as were the Negroes, since the more intelligent white women and the more intelligent Negro women kept away from the community.

In the second place, at the end of the book, some very brief statements are given about other mixed groups—for example, the Rivers, and there is nothing in the history which shows anything pathological about this very much larger group than the Wins. Whether the low mental and social status of the Wins is due to the economic and social status surrounding their lives, or whether their economic and social circumstances are due to their low mental level, cannot be decided on any of the data presented. *Furthermore, there are plenty of instances* of groups that are pure white, and Nordic white at that, living in isolated communities, whose general status, socially and mentally, is certainly as low, if not lower, than that of the Wins. The hill folk of Kentucky and Tennessee, as well as numerous other white groups, furnish excellent examples.

Consequently, nothing has been proven about racial intermixture from this study, and, furthermore, nothing is proven about the causes of the low social and mental status of this group. If men like Davenport and Estabrook want to prove anything as to the causes operating to produce such groups of low-grade people, let them take a little of the money now spent in investigating these groups—or let them get a little of the money that has been made in royalties by such writers as Wiggam, who exploit their scientific writings and researches—and perform a real experiment of social-biological importance.

Let them take a few of the Win infants, immediately after birth, and, by an appropriate sum of money, obtain the consent of their parents to relinquish their care; let these infants then be placed in social groups and under social circumstances where they will have the full benefit of civilization, its schools, its hospitals, its workshops, and, above all, its *mores*. A few such experiments will be worth all the group studies that can be made from now to Domesday, and will prove something, whereas these studies are mere recountings of the same things over and over again.

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Tufts College Medical School.

Unmasking Our Minds. By David Seabury. New York: Boni and Liveright, 1924. 429 p.

The publishers of this book tell us that the author is a foremost authority in applied psychology and that in his book he has united the useful essentials of such contrasting leaders as Freud, Jung, Adler, Watson, McDougall, James, and so forth. In the preface the

author wisely states that the book is not meant to be used as a means of self-help by the exceptionally neurotic person (for whom he recommends the special assistance of the medical psychologist), but that its purpose is to give the average individual some of the knowledge that modern dynamic psychology has to offer as to the real nature of human motives, instincts, and emotions, so that the reader may, by self-exploration, strengthen the weak points in his personality and utilize all of his native powers.

As the title would indicate, the book is written in everyday English. The use of technical terms is reduced to a minimum, and where they are used, they are quite well explained. The style is piquant, often dramatic. In the thirty-one chapters, the author discusses all the ills that mortal man is heir to, individually and collectively, and, like the physician in Samuel Butler's Utopia, *Erewhon,* he places the emphasis decidedly upon the mental side; the physical is relegated to the dim, distant background. Moreover, he is Freudian enough to state that three-quarters of human mentation takes place below the level of awareness; hence the psycho-therapeutist must concern himself mostly with the unconscious mind. He cites from the case records of a certain Dr. Ess (leaving the reader to guess that probably the doctor is none other than the author) cases of promising careers blighted by childhood conflicts which in turn had their origin in the marital discord of the parents; of a twenty-year-old chronic indigestion due to a repressed father hatred; of divorces caused by extreme parental devotion; of failures in adult life because of inhibitions heaped on in childhood; of hyperthyroidism caused by an unsatisfied hunger for adventure. He pronounces many judgments, long familiar to readers of psychoanalytic literature. For example, censors and reformers are externalizing their own conflicts; ascetics are usually libertines at heart; our present laws are based not upon the actual needs of mankind, but upon those of a hypothetical creature. But he makes some statements in the form of definitely established facts, which, to put it mildly, are far from proven or even regarded as probable by most workers in this field. He states, for example, that feebleminded-ness is caused by mental conflict within the parents (can one imagine the original Mr. and Mrs. Jukes having intense inner struggles?); that repressed forces in the parents are transmitted to the offspring; that bitter memories cause aphasia (does he mean amnesia?). His optimism also is quite unwarranted: "Countless cases of alleged insanity will be cured, once the devastating power of memory is understood."

Judging from the displays on newstands and the advertising matter in our popular magazines, there is a large class of people who are trying to resolve their conflicts by various systems of alleged mental

and physical cultures or "pathies". If the garnished brand of psychology that the author offers in this book will succeed in luring away a percentage of these individuals from such false prophets, it will accomplish a good purpose. But for the more serious-minded reader, the one who wishes to learn what the new psychology has to offer, either as a matter of knowledge or to assist in a better personal adjustment, the reviewer would recommend the last few pages of the book, wherein the author gives a really good bibliography.

H. L. Levin.

Buffalo State Hospital.

The Doctor Looks at Life. By Harold Dearden. New York: Doubleday, Page, and Company, 1924. 183 p.

The flood of books dealing with psychological cure-alls has been large since the Great War. From London we get *The Doctor Looks at Life,* obviously Doctor Dearden's attempt to bring to the nervously ill his method of diagnosing and treating their disorders. It is always difficulty to project personality upon the printed page, and the ability clearly to do so is what makes a delineator of character great, mediocre, or a failure.

Doctor Dearden has started his book with chapters entitled, *The Need for a Technique, How the Mind Works,* and *Instincts and Habits,* all of which contain material that is interesting and helpful and based on sound psychological data, if withal rather well known from frequent discussion by previous authors. The later chapters—*The Emotions, Sterile Emotions or Day-dreaming,* and *Effect of Mind on Body*—are the best of the book, especially the first, which gives us a very excellent picture of emotional fluctuations, their dangers, and, more especially, advice as to how to direct emotions into constructive paths.

In the chapter on sterile emotions or day-dreaming, a very worthwhile point is made of the danger of admitting into a court of law records in diaries. Such records notoriously contain many of our hopes and aspirations and usually little of pure fact, and yet we are accustomed to see such phantastic evidence admitted as fact in a legal case upon which the fortunes of many persons may hinge.

Effect of Mind on Body is a very strong presentation of the value of a sustained effort to cultivate constructive emotions and thereby to build a personality of courage and optimism. Many helpful hints are given as to how to do this.

Religion and Psychology represents an earnest attempt to demonstrate the value of religious faith in character building, but it is verbose and unconvincing; in fact, it has done so feebly what has

been better achieved by many other writers—notably Fosdick in this country—that it might much better have been left out.

The chapter supposed to deal entirely with treatment is again vague and full of comparisons, many of which are rather far-fetched. The author discards suggestion and psychoanalytical methods of treatment and relies upon his own method, which he has divided into three parts: (1) diagnosis, (2) convincing the conscious intelligence, and (3) appeals to the subconscious mind. With the first part of his method we have no difference of opinion. A careful physical examination is always a *sine qua non* of diagnosis, and after that come knowledge of and interest in human beings plus experience. What more could we ask for diagnosis? With the second and third components of treatment, we have a distinct "conflict". The author's exposition of them is again in the nature of airy persiflage, unconvincing and unconstructive. To tell a neurotic patient "that for what he is to-day he is himself responsible, and that in his own hands lies entirely what he will be in the future", is, perhaps, sufficient commentary to make clear my criticism of this chapter on treatment. What the patient is to-day may be the result of a long-continued struggle with poverty, infidelity, or medical mishandling, and to make such a patient shoulder the whole burden of the result of misadventure seems hardly calculated to soothe the mind or strengthen the nerves.

The concluding chapter, on physical training, brings us to a treatise on rhythmical gymnastics as the most important adjunct to the system of psychotherapeutics outlined above. It is this last chapter that makes us feel that the author of the book is a faddist who dresses up well-recognized methods of treatment of the psychoneurotic in garments of old materials with new names and cuts.

The book starts off well, encourages us to believe that we will find a new key to treatment for our nerves, grows wordy and vague, and leaves us startled and uncertain.

Arthur H. Ruggles.

Yale University.

NOTES AND COMMENTS

Legal and Administrative Aspects of Psychiatry in Some European Countries

The following summary of legal and administrative provisions for the treatment of mental patients in six European countries was taken from the *Journal of Mental Science* for July, 1925, where it appears as part of a report of the Medico-Psychological Association of Great Britain and Ireland to the Royal Commission on Lunacy and Mental Disorder. It was based on replies to a questionnaire sent out to corresponding members of the association in the countries in question and was compiled by Lieutenant-Colonel J. R. Lord, superintendent of the Horton Mental Hospital and co-editor of the *Journal of Mental Science.*

FACILITIES FOR EARLY TREATMENT OF OCCURRING MENTAL DISORDER

France.—There is no provision at present under the French law for a mental patient, on his own request and apart from his relatives and friends, to receive treatment in a mental hospital, but in the new lunacy bill now before the French parliament this is being allowed for and will be known as "spontaneous internment". A mental patient desiring treatment or not unwilling to be treated can only be received in a mental institution by the action of his relatives or friends, who effect what is known as "voluntary internment" (*un placement volontaire*). This method of placing mental patients under care is applicable whether the patient is willing or not, and will be described later. Many uncertified cases are treated in special departments attached to the general hospitals.

Dr. Henri Colin (*vide Journ. Ment. Sci.*, October, 1921, p. 461) says:

"The treatment of the psychopathies is at the present time imperfect. It only concerns itself with conditions of confirmed insanity, which has reached a stage when the chances of cure are restricted. The irksome formalities, and in a certain measure vexations, of certification keep the milder cases away. The asylum in its present form is expedient only for the dangerous and incurable insane."

Referring to treatment of voluntary or uncertified patients he says:

"In France, the law of 1838 is silent on this point. It did not foresee clinics for uncertified patients, any more than it foresaw family colonies. Now family colonies exist in France, and prosper. It will be the same with uncertified clinics; and already at Fleury-les-Aubrays, near Orléans, services exist where the patients can enter voluntarily. Thus nothing prevents the generalization of the system."

The following reply was sent by the Société Clinique de Médicine Mentale to a letter from the Minister of Health on the subject of the revision of the lunacy law of 1838:

"The expression 'mental affection', the meaning of which is wider and less precise than that of the expression 'mental alienation', denotes mental alienation and also other morbid states characterized by mental troubles. Those persons suffering from mental affections ought to be regarded as alienated—

"(1) Who compromise public order.

"(2) Who are, or may become, dangerous to themselves or others.

"(3) Who, incapable of properly managing themselves, or of supplying their needs, do not receive from their immediate *entourage* or from public assistance the supervision and care that their condition renders absolutely necessary.

"Thus, only the alienated, to the exclusion of other patients afflicted with mental disorder, ought to be the object of legal measures restrictive of individual liberty.

"The substitution of the expression mental affection for the expression mental alienation might have the consequence of improperly extending these measures. There is thus cause for avoiding such a substitution.

"Now patients suffering from mental affections in general, and not merely the alienated, deserve to be treated, and the law could extend the benefit of personal or voluntary placing to all mental affections.

"As far as this refers to the poorer classes, and if one excludes some hospital services of the large towns, the insane asylums are actually the only establishments for the treatment of mental affections in general, and there is nothing to hinder those persons suffering from mental affections, but not alienated, from being treated in the asylum, if they desire it, if they enter freely, if their stay in the establishment is medically justified, and if they leave freely, though not cured, upon the single condition that they are not dangerous. The opposition of the responsible physician to the discharge of a voluntary patient should always become the object of an immediate and careful inquiry analogous to that occurring on admission."

In France the lunacy law of 1838 has remained unchanged except for the emergency law of March 21, 1919, dealing with mentally afflicted soldiers. A projected revision of the lunacy law was interrupted by the outbreak of war. In France, as in this country, there is a volume of opinion, both medical and otherwise, in favor of voluntary treatment of early cases of mental disorder uncertified, whether certifiable or not, in the wards of infirmaries (dispensaries), general hospitals, asylums, at special clinics (with laboratories), and by attendance at the out-patient departments of dispensaries and hospitals.

In France, before a person can be sequestered as insane his insanity has to be proved, but Art. 510 of the Code Napoleon permits the "family council" to take the necessary action.

The law of 1838, like our existing lunacy laws, contemplates the treatment of all psychopathic cases under a form of certification. It has failed, however, in France as far as early treatment is concerned, and it seems likely that this will be effectively provided for in the revised law now before Parliament.

Italy.—Voluntary admissions to psychiatric hospitals and provincial asylums are permitted. Such admissions are immediately notified by the director of the hospital to the attorney of the king (*il procuratore del re*).

Art. 53 of the regulations in the law relating to asylums and the insane reads:

"When individuals of full age, being aware of their own condition of partial mental aberration, request to be received in asylums, the manager, in case of absolute urgency, and on his own responsibility, may receive them provisionally under observation, giving advice thereof within twenty-four hours to the attorney of the king, subject to reporting to him, by order of the tribunal, as in ordinary cases, and to the police authorities. The usual procedure follows.

Professor Leonardo Bianchi, a member of the Italian Senate, said on June 9, 1922:

"Our law has been inspired by the desire for the public safety, and not

from the point of view of the hospitals. In obedience to our law, only those persons are admitted who are judged to be dangerous to themselves and to others."

"There are a large number of patients whose malady springs up acutely, for instance, those who are ill from intoxication or infection, typhus, malaria, or acute alcoholism, etc., which, if they were looked after at the proper time, might be cured very rapidly. Now as for the admission of these into the lunatic asylum, it is necessary to carry through the procedure either with the police authorities or with the tribunal; it is quite natural that many families refuse to send their patients to asylums for the reason that the police authorities and the tribunal imprint an indelible mark on the honor of the family (even if this be only prejudice), and consequently, these patients remain in their own houses, either not cared for or badly cared for.

"For this reason the malady often passes into a chronic state, and it is only then that the respective patients are admitted in the lunatic asylum, but it is perhaps too late for a rational treatment; for this reason it is necessary to make different arrangements for the admittance of these patients."

Spain.—Voluntary admissions take place, but the law regarding certification is afterwards carried out on the initiative of the patient.

Holland.—Patients, on application to the tribunal, can be received voluntarily at the asylums. They can be received without authorization at the official psychiatrical clinics.

Psychiatric clinics may receive certified cases without restrictions, but general hospitals are only allowed to accommodate two certified cases.

Germany.—In Germany the care of mental patients is not regulated by a lunacy law common to the empire. Each federal state is governed in this respect by its own laws and by its government decrees. There is no special lunacy law in Prussia—only government decrees (a matter of ministerial administration).

The Baden lunacy law of June 25, 1910, is said to be well thought out and the most enlightened. Another recent lunacy law in Germany is that of Saxony dated 1912.

There appears to be ample provision for voluntary admission to all mental institutions either by the person afflicted or on his behalf by his friends. As regards asylums, the applicant for admission must produce papers of identification and guarantee payment of the cost of maintenance.

Austria.—Voluntary admissions are permitted both to psychiatric clinics and asylums. The patient writes a declaration in the presence of two witnesses and the medical officer of the institution that he agrees to stay.

CERTIFICATION AND ADMISSION TO MENTAL INSTITUTIONS.

France.—In accordance with the law of 1838, there are two methods of placing the mentally afflicted under care in public and private asylums:

(a) Voluntary internment (not ordered by the state). To effect this it is necessary to produce the following documents with the patient:

(1) The demand for admission containing the name, occupation, age, and addresses both of the patient and the person effecting the internment.

(2) A medical certificate (or several) giving mental state of patient and the reasons for internment. This certificate must not be signed by a medical officer attached to the receiving asylum, nor by one who is a relative or connection of the heads of the establishment or of the person effecting the internment.

(b) Official internment is by order of the prefect of the department (in Paris, the prefect of police), and applies to any person whose mental state

compromises public order or the safety of individuals. In urgent cases mayors of communes can act and refer the same to the prefect within 24 hours.

Judicial authority only intervenes when an insane person has broken the law.

All admissions are notified to the prefect within 24 hours of admission, with a report from the medical officer of the asylum.

Italy.—The internment of an insane person in an asylum takes place as a rule in two stages: (1) provisional; (2) confirmatory.

A relative of the person to be interned, or the guardian, acting guardian, or trustee, obtains a detailed medical certificate from the doctor in charge of the case (who must not be a relative, even in the fourth degree, of the patient or of the manager or the owner of the asylum or nursing home selected, nor may he belong to such asylum or nursing home). He then proceeds to the magistrate, or, in communes which have not a district court, to the mayor, with four witnesses, who are not members of the family of the patient and are acquainted with the patient, if possible residing in the neighborhood of the latter, who have the legal position and are persons of good repute and worthy of confidence. The latter must confirm the statements written by the doctor, and the circumstances which lead to conclude the state of mental aberration of the individual. The "act of notoriety" arises in this way.

Then, on the basis of the medical certificate and the "act of notoriety", the magistrate issues a "decree of provisional retention" in an asylum, which authorizes the manager to receive the patient.

The manager immediately advises the attorney of the king of the internment effected, and within 15 days (if the diagnosis cannot be effected within this period, a further 15 days may be asked for and obtained, but not a day longer) it must be declared to the attorney of the king that the internment of the patient in the asylum is considered absolutely necessary (dangerous to himself or others). Then the tribunal issues and sends to the manager a "decree of definite retention".

Spain.—The internment is in two stages: (1) provisional; (2) confirmatory.

Two medical certificates are required for the former and the provisional order is made by the mayor. Other formalities prior to admission are the examination of the patient by the medical officer of health (*subdelegado*). The *subdelegado* seldom visits the patient, but always receives a fee for his signature and seal. Municipal practices vary, but the mayor, before he signs the order, usually orders further investigations by two municipal physicians, whose reports are confidential.

After three months the order is confirmed if necessary by the judicial authorities after inquiry and reports from the medical director of the asylum and the medical adviser to the court of justice. The judicial authority means a judge sitting as in a civil suit. The application is first heard by a local magistrate, and notified in the official journal of the province 30 days beforehand.

Holland.—The internment is in two stages: (1) provisional; (2) confirmatory.

The internment in an asylum is effected by the members of the family and an order from a cantonal magistrate.

One medical certificate must be submitted giving the mental state of the patient and the need for internment. The order is effective for six weeks.

At the end of this time the tribunal can extend the order to one year, which is renewable annually.

Germany.—(*a*) Public clinics: The psychiatric and neurological clinics admit quite freely the mentally afflicted or people suspected of such, and no medical certificate or judicial order is required. As a rule a medical report accompanies

the case. They also admit without formalities persons ordered there for observation by the civil and criminal courts and the police authorities for several reasons.

(*b*) Public asylums, like the clinics, admit without formalities police and court cases.

In the case of a patient for whom internment is necessary the following documents must be produced: (*a*) a police certificate as to the patient's origin, family, and circumstances; (*b*) a guarantee or statement as to the payment of the cost of maintenance; (*c*) a written declaration of consent by the legal representative, or by the "competent authority"; (*d*) one detailed medical certificate. The application as a rule is addressed to the "provincial captaincy", which is the head of the provincial administration. The following persons are entitled to make such applications: (*a*) poor-law authorities; (*b*) the nearest relative or the legal representative (guardian or trustee of the patient). These provisions are not absolutely uniform in all states or provinces. There is no judicial authority required.

The following extracts from the Bavarian codes of penal and civil procedure and police penal codes are interesting as illustrative of German lunacy procedure in certain cases:

Section 18 of the Code of Penal Procedure

For the preparation of an opinion on the mental condition of the accused party, the court, on the application of an expert, after hearing the defending counsel, may order that the accused person be conveyed to a public lunatic asylum, and that he be observed there.

A defending counsel must be appointed for an accused person who has not one.

Immediate objection can be lodged against this decision. (The effect of this is to defer its action.)

The internment in the institute may not exceed the period of six weeks.

Section 656 of the Code of Civil Procedure

With the consent of the applicant, the court may order that the person interdicted be brought for a period not exceeding six weeks into a curative establishment, if this appears to be desirable, according to medical opinion, in order to ascertain his mental condition, and if this can be carried out without detriment to the condition of health of the person to be interdicted. (Before the decision the persons referred to in section 646 should be heard as far as practicable.)

Against the decision by which the internment is ordered, the person to be interdicted, the state prosecutor, and within the term granted to the person to be interdicted, the other persons mentioned in section 646, have the right to lodge an opposition immediately.

Article 80 of the Bavarian Police Penal Code

Any one who, to the danger of persons or property, or to the danger of public morality, allows idiots or mental patients whose supervision is incumbent on him to go about freely in the streets or in public places, will be punished by a money fine up to 15 thalers (now up to 45 marks).

If such a person has made an attack against persons or property belonging to others, or has acted contrary to public morality, and either no penal proceedings have even been instituted because the accused

person is not responsible for his actions, or a recognition of this has caused the penal procedure to be stopped, or if the danger to the community of such a person has been ascertained in some other way, the police authorities are entitled, on the basis of an opinion of the district medical authority, to order the internment of such a person in a lunatic asylum or sufficient supervision to be exercised over him in some other way.

Article 81(d) of the Bavarian Police Penal Code

Any one who allows children, sick persons, defective or idiots or other such-like helpless persons belonging or entrusted to him to be neglected in regard to protection, supervision, care, or medical assistance, will be punished by a money fine up to 30 thalers (now up to 90 marks), or by imprisonment up to four weeks.

In the penal judgment it may be decided that the police authorities are empowered to care in some other way for the accommodation of the persons in question at the cost of those whose duty it is to do so. The power to do this, when it is a question of a measure for which an order of the chancery court is required, is dependent on the granting of the said order.

Austria.—A distinction is made as to whether the person to be dealt with is suspected of mental disorder or is a case of undoubted psychosis.

In the former case the internment is in a clinic (observation station) and not in a public asylum. It is effected on the certificate of the official medical officer (police physician, district physician, etc.). The clinic ascertains the patient's mental state and, if normal, discharges him. If found to be suffering from mental disorder, his transfer to the nearest asylum is ordered.

For admission to a public asylum, one certificate is necessary as to the mental state of the patient, which must also state that the patient is dangerous as regards himself and his environment. As a rule this certificate is issued by the district medical officer except in "urgency cases", when any practitioner can certify, in which case the director of the asylum must send a report within 24 hours to the police commissariat or district captaincy. Examination by the district medical officer follows.

Every case admitted to a public asylum is notified to the provincial courts (civil), following which the patient is examined medico-legally (by one judge, one or two court psychiatrists, and one secretary) to decide whether the internment is admissible. A subsequent examination by the provincial court is held to settle any question of guardianship.

URGENCY CASES (ADDITIONAL NOTES)

France.—The medical certificate can be dispensed with.

Italy.—In cases of urgency (or in order to avoid the slowness of the ordinary procedure with the magistrate), the relative of the insane person to be interned, furnished with the medical certificate, can obtain a decree of provisional retention from the police authorities. The subsequent official formalities are the same as in ordinary cases.

Spain.—The mayor or magistrate or governor of the province may decide on immediate internment, but the ordinary procedure must follow.

Holland.—Can be dealt with by the mayor of the municipality instead of the cantonal magistrate. The case can be received in any large hospital.

Germany.—Urgent internment can be effected without medical certificate. The medical officer of the asylum certifies afterwards.

Austria.—Certificate of any medical practitioner is sufficient to effect internment. The police authorities are notified within 24 hours.

SPECIAL PROVISIONS FOR PAYING PATIENTS

France.—There are private hospitals which are subject to the same regulations as the public asylums, except that the prefect immediately orders an examination by a psychiatric inspector. There are also "pensionnats" attached to certain public asylums. Certification does not differ.

Italy.—All private mental institutions are subject to the same laws as the public asylums. Certification does not differ. The same applies to patients treated at home or in nursing homes.

Spain.—The same as Italy in this respect.

Holland.—There is no difference in the law as regards paying and non-paying patients. There are sanatoria in which paying patients place themselves for treatment as nerve patients. If necessary, they are certified and sent to the mental division of the institution.

Germany.—There are many private mental institutions, homes, etc., and private mental nursing agencies.

Paying patients in limited numbers can be received in public mental hospitals. There may be several classes of paying patients. In Berlin there is only one class of mental hospital, which includes those who pay and those who do not.

The medical certificate presented on admission must be made out by the district medical officer or the director of a public mental hospital or clinic. If the patient is already under guardianship, then if the admission is authorized by the guardian, the certificate of any medical practitioner suffices.

Urgent admissions on the certificate of any medical man are allowed, but the district medical officer must then be notified within 24 hours, who examines the patient within 3 days after the receipt of the notice.

Voluntary admission to private institutions is permitted on the production of the following documents:

(*a*) A medical certificate that the patient understands all about the admission and that he is a suitable case for care and treatment.

(*b*) The written declaration of the patient that he wishes to enter the hospital.

Austria.—There are some private sanatoria for mental cases and "paying departments" in the mental hospitals.

The law regarding admission is the same as in the case of public mental hospitals.

DISCHARGE OF PATIENTS

France:

Recovered.—By the asylum in the case of "voluntary internment".

By the prefect in the case of "official internment".

By the attorney of the republic in the case of minors of a person "interdicted".

Not recovered.—If interned "voluntarily", by the relatives or guardian or other person who has effected the internment unless the medical officer deems the patient to be dangerous. Discharge is then suspended and the prefect informed, who converts the "voluntary internment" into an "official internment".

Italy:

Recovered.—By the psychiatric hospital to his family.

If the family do not remove him, then the president of the tribunal or the police authorities or the mayor of the commune at the place of origin of the patient is notified to effect the removal.

Recovered.—By the asylum to his family.

If the family do not remove him, then the police authorities effect removal.

Not recovered.—The patient who is improved, but not recovered, however, may be discharged "under the legal responsibility of the manager" (who may secure himself by requiring a signature of guarantee on the part of the relative who takes charge of the patient. This signature has, however, only a moral and not a legal value.)

Advice of "discharge recovered" is immediately given to the police authorities and to the attorney of the king, who must then obtain from the tribunal a "decree of definitive discharge", which is, however, usually issued a long time after the patient comes out.

Advice of "discharge improved" is given to the attorney of the king, to the police authorities, and to the mayor of the commune to which the patient belongs. During the trial period of the patient the family must send, through the mayor, a medical certificate respecting the state of the said patient to the manager every four months.

When the manager declares an improved patient on trial has recovered, he gives advice of same to the attorney of the king in order that he may obtain the "decree of definitive discharge" mentioned above.

If, during the trial period, it is found to be necessary for the patient to return to the asylum, he is readmitted on production of a simple medical certificate. The manager must at once inform the attorney of the king, sending him a certified copy of this certificate.

Professor Leonardo Bianchi, in the speech already quoted, said:

"Now I think we ought to be interested in the insane person on his own account; because he is ill, we ought to conceive of the institutions for mental diseases as hospital institutions, and not only from the point of view of public safety, for the so-called persons who are dangerous to themselves and to others. Moreover, the law is contradicted by the fact in that all those who are sent to and received by a lunatic asylum when they are dangerous, if they are not perfectly cured, remain as inmates of the lunatic asylum even when they have become quiet. In this the law contradicts itself, because it is vain to prescribe internment only for dangerous lunatics when from the technical point of view it is not possible to judge as to whether they have become inoffensive, and when there is no means of obliging the families and other public institutions to take over those who were interned on account of a psychiatric episode which rendered them temporarily dangerous. And there is another reason of contradiction between the provisions of the law and the practical fact. As the judging of the inoffensiveness is not absolute, but relative, as regards insane persons who are not perfectly cured, there is no director, however generous he may be, cultivated, and of strong mind, who would expose himself to the rigors of the law by releasing alienated persons whom he judges to be no longer dangerous, who could be useful members of society, especially if they are farm laborers and assisted by their families, because the law in the first paragraph of Art. 3 attributes to the director of the lunatic asylum the responsibility for the acts which the discharged lunatic may at any time commit. In fact, in this it is stated: The director may discharge a patient who is no longer in a condition of being dangerous, but only on his own responsibility.

"This factor, restrictive as to the discharge of insane persons from the

psychiatric hospital, must be suppressed. These institutions must be allowed to breathe; the discharge of the patient should be left to the judgment of the sanitary authorities, who know, moreover, the surroundings to which the lunatic will or will not be entrusted."

Spain:

Recovered and not recovered.—By the asylum and by the relatives, the governor of the province being notified.

Holland:

Recovered.—By the clinics, hospitals, and asylums.

Not recovered.—By the clinics, hospitals, and asylums, on trial. A special provision in the law enacts that an insane patient, through not recovered, may be discharged, if the cost of his maintenance is not forthcoming.

Germany:

Recovered.—By the clinics and asylums.

Not recovered.—(*a*) Patients can be discharged on trial.

(*b*) On the undertaking of his relatives to be responsible for him and all the consequences following his discharge. Regarding dangerous cases, on such an application being made, the police authorities are informed, and if they do not act within 3 weeks the patient must be allowed to go. If the police decide against the discharge, the patient remains in hospital.

The patient must be discharged, whether recovered or not—

(*a*) If "guardianship" has been refused by a court;

(*b*) If the legal representative demands discharge and the police sanction it.

The police are informed when it is proposed to discharge or allow out on trial cases admitted from prison or from the courts.

As regards private institutions, a patient not a minor or under guardianship, on applying for his discharge in writing, the head of the institution, if he does not comply with the request, must transmit the same with a report to the public prosecutor.

Austria:

Recovered.—By the asylum. In "guardianship" cases the discharge must be notified to the "competent court".

Not recovered.—By the asylum to the care of relatives and on a suitable undertaking when necessary. In the latter case the police authorities, political authorities, district captaincy, and others must investigate the question whether the person giving the undertaking can carry it out and need to approve of the discharge. Harmless chronics can be sent to infirmaries and colonies.

STATE SUPERVISION OF MENTAL HOSPITALS

France.—Supervision is exercised by the minister of the interior through the prefect, the mayor, the attorney of the republic, the magistrates who visit the hospitals. The patients are regularly examined by psychiatric inspectors commissioned by the prefect.

Italy.—Supervision is exercised by a provincial commission formed by the prefect, the provincial medical officer, and a psychiatrist. The commission visits the asylums once every year.

Professor Leonardo Bianchi remarks:

"The same thing has happened with the inspections of lunatic asylums; the medical man and director of a lunatic asylum become for some time members of the commission of vigilance of other lunatic asylums; thus they are inspectors, but, in their turn, they must suffer inspection as the other institutions. It is needless to examine the objections as to this. On the other hand, it is known

by everybody that the inspections are made once a year; it is known that the prefecture is preparing the inspections, and it is understood that everything goes well. But the character of the inspections is extraordinarily delicate as regards lunatic asylums, because it is a question not only of making sure whether the registers required by the regulations exist and whether things are kept in hygienic conditions and the clinical records are kept, but to make sure that there are not kept in lunatic asylums persons who ought not to be retained there; the law is specially preoccupied with respect to the liberty of the citizens.''

Spain.—Supervision is nominally by the minister of the interior, who delegates, through the governor of the province, the provincial sanitary inspector to pay visits of inspection.

Holland.—The state provides two inspectors of lunacy, who visit the asylums whenever they wish.

Germany.—Supervision is exercised by the chief president of the federal state, and the asylums are inspected annually by a visiting commission composed of a medical councillor, an experienced mental specialist, and, in some cases, a state medical officer. In some states these inspections have ceased during the past year or so.

Austria.—Psychiatric clinics are subject to the minister of education. There is only provincial control. There are no state inspectors.

PSYCHIATRIC CLINICS AND SIMILAR PROVISIONS

France.—In the cities and large towns the ordinary hospitals have wards, where patients suffering from mental disorders and who are not certifiable are treated.

Italy.—There are municipal psychiatric hospitals, and some clinics are separate institutions maintained by the state. Provision is inadequate for recent cases, because only dangerous and chronic patients can be received in the provincial asylums. It is proposed that some twelve to fourteen neurological clinics should take mental cases.

Spain.—General hospitals only have psychiatric clinics attached, but not all of them. Some of their regulations exclude mental cases.

Holland.—The clinic system is well-developed and encouraged. Psychiatric clinics are connected with universities and other medical clinics. Asylums also have attached ''approved institutions'' for uncertified cases. The doctors of the asylum are prohibited from certifying these cases if the necessity for such arises.

Germany.—Clinics are only in connection with the universities. In certain large general hospitals mental patients are temporarily admitted, but no prolonged treatment takes place. Patients who do not recover early are transferred to the asylum.

Austria.—Psychiatric clinics only exist in connection with three universities. Some of the large general hospitals receive mental cases temporarily, but only to pass them on to the clinics or asylums.

AFTER-CARE

France.—Patients who do useful work while under care in the asylums receive remuneration. Part of this money is retained by the asylum and handed to the patient on discharge. Necessitous patients may, on discharge, receive assistance to help them while seeking employment.

There appears to be no ''after-care'' as we know it in England.

Italy.—There exists in connection with some asylums a society for the assistance of the insane poor, which, in addition to grants of money, has recently been providing the means for re-adapting the insane for outside life and employment. But these funds depend on private contributions, and are independent of the administration of the asylums. The manager of the asylum, however, is generally president of the society.

Spain.—There is no "after-care" and no grant to necessitous patients on discharge.

Holland.—There are no grants from official funds to indigent patients on discharge. There are private funds, however, which help in this direction.

Germany.—Slight pecuniary assistance is given from public and private funds to assist patients on discharge. Patients may also be discharged to "welfare centers" in some cities. In some provinces there are "associations for aiding discharged mental patients".

Austria.—No grants are made from public funds to poor patients on discharge. Private charities, such as that in Vienna known as the "Association for the Support of Persons Discharged from Curative Establishments", may assist some cases.

Suggestions for a Course of Training for Psychiatric Social Work

The executive committee of the Section on Psychiatric Social Work of the American Association of Hospital Social Workers, now the American Association of Psychiatric Social Workers, has tentatively formulated the following suggestions in regard to the training of psychiatric social workers. The committee is composed of Mrs. Maida H. Solomon, Boston, president; June Lyday, Iowa City, vice-president; Margaret L. Wirt, Boston, secretary-treasurer; Mary C. Jarrett, Boston; Katharine Moore, Chicago; Helen L. Myrick, Chicago; and Mrs. Margaret J. Powers, New York City.

Requirements for admission: No student is accepted who is under twenty-one years of age or is still engaged in undergraduate college work, since an adult point of view is essential in this field.

Completion of a full college course is a prerequisite, or an equivalment education in exceptional cases.

Certain personal qualifications, in addition to intelligence and general ability, are essential. They are described as follows in the vocational pamphlet prepared by the Section on Psychiatric Social Work: "It is generally agreed that the psychiatric social worker should possess those qualities that are required for any type of professional work, should be intelligent, alert, sympathetic, well poised, and adaptable, and should have an objective attitude, ability for clear analysis, and interest in experimentation. She should be in good physical and mental health, old enough to have a certain maturity in point of view and young enough to be flexible in her attitudes. She must be able to deal with all sorts of persons in a manner that wins confidence, recognizing the superior knowledge of her associates in the fields in which they have had special training, but possessing the initiative, independence, and vision to develop her own work to its highest potentialities".[1]

[1] See *Vocational Aspects of Psychiatric Social Work.* Mental Hygiene, Vol. 9, July, 1925. P. 572.

Length of the course: "The training courses cover from fourteen to eighteen months of academic work."[1] The course may be given in two academic years or in a continuous period with one or more short vacations.

Relation of study and practice: The practice of social case-work in psychiatric problems is the foundation of the course. It is only through practice and experience with patients that the student can acquire the habitual attitudes and the adaptable technique necessary for success in psychiatric social work. The theoretical courses and academic exercises contribute to this object by furnishing information and theories, and they also provide the background of knowledge that is essential to a broad grasp of the subject of psychiatric social work and inculcate the scientific attitude that should differentiate the trained from the untrained social worker.

The practice work is the most difficult part of the course to plan. The whole matter of practical training is in an experimental stage, and there are no precedents that can be accepted unconditionally. Several conflicting methods are advocated in regard to (1) the amount and distribution of time to be given to practice work, (2) the type of social supervision to be given, and (3) the type of psychiatric agency to be used.

Amount and distribution of time for practice: It seems to be generally agreed that nine months, or over 1,400 hours of the course, should be devoted to practice work. This is also in accord with the *Report of the Committee on Training for Hospital Social Work.*[2]

The distribution of the time given to practice work is the most difficult problem in planning the course. The original method in schools of social work was to devote a number of hours each week to practice. "The time so spent has increased in most schools from two hours to two or three days, as the schools have realized the futility of having students try to handle practical problems in short bits of time; certain schools, finding that their students' practice still lacked continuity, have devoted 'blocks' of time to it."[3] Two weeks or a month of full time at intervals are given to practice work in several schools, supplementing the usual two or three days a week. The school at Smith College devotes nine months to continuous practice. At the New York School approximately one-half of the total amount of time required for the earning of a diploma is spent in field work.

Continuity and concentration in experience with patients is particularly important in psychiatric social work. The field is still so new that it is possible to plan training courses according to its needs and not merely in accordance with customs in other fields of social work. In planning a course, careful consideration should be given to principles of training in social case-work as applied in the field of mental hygiene and to their adaptation to local facilities.

The method of full-time practice work for a period of six or nine months has not received much general discussion owing to the fact that, in schools where other courses were given by the earlier method, the courses in psychiatric social work were naturally planned along similar lines. It seems desirable that there should be a full discussion of this method with reference to this field.

There are three important points to be considered: (a) continuity in the case-

[1] *Vocational Aspects of Psychiatric Social Work,* p. 573.

[2] *Report of the Committee on Training for Hospital Social Work.* (American Hospital Association Bulletin, No. 55.) Chicago: American Hospital Association, 1923. P. 20.

[3] *Idem,* p. 19.

work, (b) the correlation of theory and practice, and (c) the work of the agency used as a field for practice.

(a) *Continuity in the case-work:* In psychiatric cases particularly, much depends on the patient's confidential relation to the social worker, and one worker at a time should have the responsibility for the case. When the student is not on duty continuously, it is almost impossible to allow her to take responsibility for cases. Also, the student who is on full-time duty, through a more intimate knowledge of the agency, acquires early a more responsible attitude toward the case-work and can be trusted with more responsible work.

(b) *Correlation of theory and practice:* In a good course, theory and practice are never divorced either in the class work or the field work, for the theoretical courses are given with reference to practical application and the theory of field work is analyzed with the student by the supervisor in the agency and the school supervisor.

The question here is whether study and practice can best be carried on side by side with approximately one-half of the week devoted to each, or in special periods devoted primarily to study or to practice. By the latter method, periods for study come best at the beginning and end of the course, with a practice period of at least nine months in between. A small amount of study should be required in the practice period and a small amount of practical experience might be required in the study period. The student's natural desire to begin some practical work as early as possible must be considered.

The advantages of full-time practice work, in giving the student deeper insight, a more comprehensive grasp of her work, and more responsible duties, should be weighed carefully in connection with the question whether there is an equal advantage in carrying on the class work and the practice work at the same time. The question here is to what extent and in what way is the daily work in the classroom related to the daily work in the field?

(c) *The work of the agency:* A student who is on duty every day for a considerable period may be a help to the agency after a short time. As soon as she becomes familiar with the situation, her services may be used in such a way that she more than repays the time her training requires from the agency.

2. *Type of social supervision:* It is generally agreed that family case-work is an essential of social case-work training. The question has arisen whether experience in family case-work can be obtained best in a family welfare agency or in a psychiatric agency. A large proportion, if not a majority, of psychiatric cases present family problems. The question is whether the student would receive a better foundation in case-work by spending a period of from one to three months in a family welfare agency before beginning case-work in the psychiatric agency. Would she gain points of view in the former that she would not receive in the latter? It has been said that the student who has had no experience in a social agency, outside of the psychiatric clinic or hospital, is apt to have a narrow view of social work. An argument against this arrangement of time is that, at present, the supervision in the family agency may lack the mental-hygiene point of view. A supplementary period in a social agency at the end of the course has also been suggested.

The only solution of this problem that is possible under present-day conditions

seems to be to effect the best combination of supervision and instruction in case-work that the local situation affords, taking into consideration the importance of the mental-hygiene point of view from the beginning to the end of the course, continuity in case-work, breadth of view, and the expertness of the supervision.

The daily case-work should be graded and supervised in the agency by some systematic method. In addition, a supervisor from the school should systematically ascertain that the student is making satisfactory progress in her understanding and attitudes as well as in her accomplishment.

3. *Type of medical agency:* There are two main questions to be met here: (1) whether satisfactory training can be given in a clinic dealing only with children or in a clinic or hospital dealing only with adults; and (2) whether satisfactory training for mental-hygiene work can be given in a psychiatric agency dealing with cases of mental disease only or of mental defect only.

The principle underlying both of these practical questions is the psychiatric content required for a sound and thorough preparation for psychiatric social work, which has not yet been generally agreed upon. It is obvious that lecture courses in any particular subdivision of social psychiatry do not entirely take the place of personal experience with those phases of the subject. It is also clear that every psychiatric agency cannot offer the student direct experience with all types of psychiatric cases.

In a psychiatric clinic and hospital, the student comes in contact with every type of patient. But there are special clinics, serving a more or less limited group of patients, in which good medical and social supervision are available. The same is true in certain schools for the feebleminded. If a student wishes to work especially with the feebleminded, would she do better to have her practice work entirely in that field? If she intends to work with children having behavior problems, is it better for her to have all of her practice work with children?

Another question that arises here is whether direct contact with ward patients is an essential part of complete training. This question also goes back to the fundamental inquiry: How much knowledge of psychiatry—that is, of both mental disorders and mental hygiene—should be expected of a trained psychiatric social worker?

The questions involved here call for more careful formulation, discussion, and experimentation, before a satisfactory solution is reached.

Courses: The *Report of the Committee on Training for Hospital Social Work* in 1923 [1] presents a curriculum for psychiatric social work that was carefully prepared and is probably as adequate as a two-year course can be made.

It seems to be agreed generally that all of the courses given in preparation for psychiatric social work should have a direct and practical bearing upon the case-work; that the theory should be taught from the point of view of its application to actual case problems; and that the case method, the discussion of actual cases, should be used in all courses as far as possible.

Thesis: The writing of a thesis on some psychiatric-social subject is considered especially important as training for the preparation of reports, which the student will be called upon to write in her later work. As far as possible the studies undertaken should have intrinsic value and should be an addition to our knowledge of the subject. The main value of the thesis, however, lies in the training it gives the student. The subject chosen should be social rather than primarily medical.

Mental hygiene of the student: The students should be encouraged to make the most of the opportunities offered by the course for improving their own mental

[1] See note 2, page 658.

hygiene and correcting their own personality defects. The school should offer the students opportunities for consultation concerning their personal problems of adjustment.

Annual Statistics of Defective, Dependent, and Delinquent Classes in Institutions

At the request of representatives of several organizations actively interested in the compilation of statistics relating to crime and insanity, a conference, called by the Director of the Census, was held at the Bureau of the Census in Washington on April 28 last, to consider what could be done toward providing for the annual compilation of statistics relating to the inmates of prisons and reformatories, hospitals for the insane, and other institutions for the defective, dependent, and delinquent classes, the decennial compilations authorized by the existing law being deemed insufficient.

The conference was attended by the following persons: Sanford Bates, President of the American Prison Association and Commissioner of Correction of Massachusetts; E. R. Cass, General Secretary of the American Prison Association and the New York State Prison Association; Frederic B. Crossley, Chairman of the Committee on Records and Statistics of the American Institute of Criminal Law and Criminology; Emil Frankel, Statistician of the Pennsylvania State Department of Welfare; Dr. Hastings H. Hart, Consultant in Delinquency and Penology of the Russell Sage Foundation; Horatio M. Pollock, Statistician of the New York State Hospital Commission, and representing the American Psychiatric Association and the American Statistical Association; Dr. Frankwood E. Williams, Medical Director, The National Committee for Mental Hygiene; Dr. George K. Pratt, Assistant to the Medical Director of The National Committee for Mental Hygiene; and Professor Sam B. Warner, Director of the Committee on Records and Statistics of the American Institute of Criminal Law and Criminology. The Census Bureau was represented by William M. Steuart, Director of the Census; Dr. Joseph A. Hill, Assistant to the Director; and Leon N. Truesdell, Chief Statistician for Population. The resolutions passed by the conference, which are given below, have since been approved by Secretary Hoover, and beginning with this year, annual statistics are to be compiled.

RESOLUTIONS

Section One

WHEREAS, it has become evident that in the rapid current of our present social life more frequent compilation of data in regard to the mentally ill, the feebleminded, the epileptic, the delinquent, and other dependent and abnormal groups is needed, in order to plan adequately for the care and treatment of

these classes and for the prevention of the social disorders and social problems that arise from the presence of these individuals in the community; and

WHEREAS, several national organizations, including the American Psychiatric Association, the American Statistical Association, the American Institute of Criminal Law and Criminology, the American Prison Association, and The National Committee for Mental Hygiene, have already gone on record in favor of annual institutional statistics as herein requested; and

WHEREAS, such data will be eagerly sought by managers of Federal, state, and city institutions, by legislative committees, by state supervisory departments, by social agencies, by departments of sociology in the universities, and by many persons in private life who are deeply interested in social problems; and

WHEREAS, the compilation of such data at ten-year intervals as heretofore is not sufficiently frequent to answer the requirements, therefore be it resolved

I. That the Bureau of the Census, of the Department of Commerce, should be authorized to collect statistics regarding institutional classes annually, instead of only decennially;

II. That it is the sense of this committee that increasing emphasis should be placed by the Census Bureau on social statistics, to supplement and reënforce the excellent and exhaustive business statistics now gathered by said bureau, and that said social statistics should cover the subjects of mental disease, criminology, poverty, etc., reliable information as to which is essential if our national life and business is to be improved along sound and scientific lines; and

III. That it is the opinion of this committee that the Bureau of the Census should serve as a central office to compile statistics on the basis of reports made by the different institutions, and that the success of the central office under such a plan must depend largely on the coöperation of the states and institutions.

Section Two

WHEREAS, the efforts of the American Psychiatric Association and The National Committee for Mental Hygiene during the past nine years in the establishment of a system of uniform statistics in state hospitals throughout the country have laid the foundation and make now practicable the collection of annual statistics on a nation-wide basis, therefore be it resolved

IV. That the Federal Census Bureau be requested to collect statistics annually of patients in public and private institutions (exclusive of those for temporary care) for mental disease, mental defects, and epilepsy;

V. That data on the following subjects be collected, tabulated and published:

a. Movement of patients by sex
b. Mental classification of first admissions by sex
c. Race, nativity, and parentage of first admissions by sex
d. Data for readmissions, to be the same as for first admissions (see b and c)
e. Mental classification of discharges, by sex and by condition on discharge
f. Mental classification of deaths, by sex and by cause of death
g. General information and administrative personnel of state hospitals for mental disease and epilepsy and schools for the feebleminded
h. Financial operations of state hospitals for mental disease and epilepsy and schools for the feebleminded.

VI. That these data be obtained:

a. From central state agencies in the several states, so far as possible
b. From institutions which could supply satisfactory correlated tables, in states where central boards do not exist

c. Individual schedules to be obtained by the Federal Census Bureau from such institutions as could not supply satisfactory correlated tables.

VII. That efforts should be made to obtain data for 1926 from as many institutions as are equipped to give it, in the expectation that the report for 1927 will be more complete, and that for 1928 still more complete; and

VIII. That all institutions for the care of the insane, feebleminded, and epileptic be urged to furnish annually to the Bureau of the Census the data necessary for the compilation of statistics, as outlined above.

Section Three

WHEREAS, there is a general and increasing demand for authentic information as to the causes, the extent, and the increase or decrease of crime; and

WHEREAS, it is essential in dealing with the perplexing problem of crime that comparable and authoritative annual statistics concerning crime and criminals be collected from the Federal, state, county, and municipal agencies involved in the administration of criminal justice, including police, prosecuting attorneys, courts, and penal institutions; and

WHEREAS, of these various agencies penal institutions are at present best organized to furnish the information necessary for the publication of such statistics now, therefore, be it resolved

IX. That the Bureau of the Census, of the Department of Commerce, be urged to include in its program the publication of annual criminal statistics and that such publication be commenced by arranging for the immediate collection, tabulation, and publication of annual statistics relative to the inmates of penal institutions.

Section Four

WHEREAS, it is ultimately desirable that statistics be published relating to inmates of all penal institutions, Federal, state, county, and municipal; but recognizing the difficulty of obtaining the information necessary for such statistics from county and municipal institutions at this time, be it resolved

X. That all state penal institutions be urged through the Federal Census Bureau to furnish annually the tables or data necessary for annual national statistics directly to the Bureau of the Census; and

XI. That all state bureaus or departments having control or supervision over penal institutions be urged to collect and tabulate, for possible future compilation by the Bureau of the Census, data with reference to county and municipal institutions.

Section Five

WHEREAS, certain work preliminary to obtaining statistics from state penal institutions has been accomplished by volunteer committees of the American Institute of Criminal Law and Criminology and the American Prison Association, and a sample record card and forms for statistical tables, approved by the Bureau of the Census, have been distributed to, and are now used by, many of such institutions, be it resolved

XII. That the continued use of records similar to those above referred to be considered by the Bureau of the Census, in order that minimum standard statistics consistent with the possibilities of the institutions may be collected;

XIII. That the Census Bureau be requested to make immediate arrangements to collect and tabulate the statistics referred to from such of the state penal institutions as are equipped to furnish them for the calendar year 1926, and that *all* state penal institutions furnish, beginning January 1, 1927, the information with regard to inmates committed during 1927, and forward it promptly to the

Census Bureau in such manner and at such times as it may direct and on forms prescribed by it, not inconsistent with the record card above referred to.

Section Six

Be it further resolved

XIV. That better results may be expected and a greater degree of accuracy and reliability achieved if the work of tabulating and correlating statistics (whether gathered by the Census Bureau direct or by the various states) be done by the Census Bureau;

XV. That it is desirable that a manual of instructions and information for the gathering of data by courts, institutions, and other agencies be prepared and submitted for approval to the Census Bureau by this committee and that the Census Bureau be requested to print and circulate the same; and

XVI. That this committee expresses its willingness to assist the Census Bureau in every way in its work of gathering statistics and suggests the appointment of sub-committees to meet and confer with the director at his convenience.

American Association of Psychiatric Social Workers

The Section on Psychiatric Social Work of the American Association of Hospital Social Workers formally disbanded at the annual meeting held at Cleveland on May 26, 1926, and a new, independent organization, the American Association of Psychiatric Social Workers, was formed. For the past year the members of the Section on Psychiatric Social Work have been considering, whether—in view of the relation of psychiatric social work to the whole field of social work—it would be to the best interests of the professional group of psychiatric social workers to continue as a part of a larger group whose interests are primarily medical and centered to a large extent in hospitals. As the greatest developments in recent years in psychiatric social work have been outside of the hospital field and more closely allied to general social work, after careful consideration, the Section on Psychiatric Social Work decided to withdraw from the parent organization. The American Association of Hospital Social Workers has maintained cordial relations with its section during the past year of indecision and has helped in every way to facilitate the plans for reorganization. The new Association of Psychiatric Social Workers realizes that it has been of inestimable value during the period of initial growth to have been affiliated with a larger, well-established professional group of hospital social workers, and does not expect that the separation will lessen the coöperation between the two bodies.

The officers of the American Association of Psychiatric Social Workers are: Maida H. Solomon, Boston Psychopathic Hospital, president; June Lyday, Iowa Psychopathic Hospital, vice-president; and Kathleen Ormsby, The National Committee for Mental Hygiene, secretary-treasurer. The members of the executive committee are Sarah Ivins, Bureau of Children's Guidance; Mary C. Jarrett; Grace F. Marcus, The National Committee for Mental Hygiene; Katharine

Moore, Michael Reese Dispensary; Helen L. Myrick, Illinois Society for Mental Hygiene; and Mildred C. Scoville, Commonwealth Fund.

The work of the association is indicated by the recommendations made by the president in her annual report to the members:

1. That a general study of the preparation required for psychiatric social work, together with an intimate survey of courses now being given and their possibilities, be made by the training committee, coöperating with the work now under way by the educational secretary of the American Association of Hospital Social Workers.

2. That an effort be made by section members representing psychiatric social work in different localities to recruit more workers from colleges through lectures or appointments with small groups of students.

3. That the effort to secure funds for case-work research be continued.

4. That informal local groups of members be formed, either independent of already existing local groups of psychiatric social workers when the local membership has only a small minority of national members, or as part of already existing local groups when the local membership has a large majority of national members. Through such groups of members not only important local and national problems can be studied, but a medium is offered for the discussion of questions of importance to the national organization.

5. That the regular semiannual meeting with the American Hospital Association be discontinued, to be replaced biennially by a semiannual meeting with a health group decided on by the executive committee, the annual meeting continuing as heretofore at the time of the National Conference of Social Work.

6. That the program at the annual meeting consist mainly of round tables on problems in psychiatric social work, with a limited number of general meetings in coöperation with such groups as the American Association of Hospital Social Workers, the National Conference of Social Workers, and so on.

7. That an effort be made each year to put aside a surplus, however small, so that a permanent endowment fund may be encouraged.

8. That an educational program be developed through enlarging the number of places where we exhibit, to include some of the state conferences; through the development of a national bulletin by the publications committee; and by the publication of our annual proceedings.

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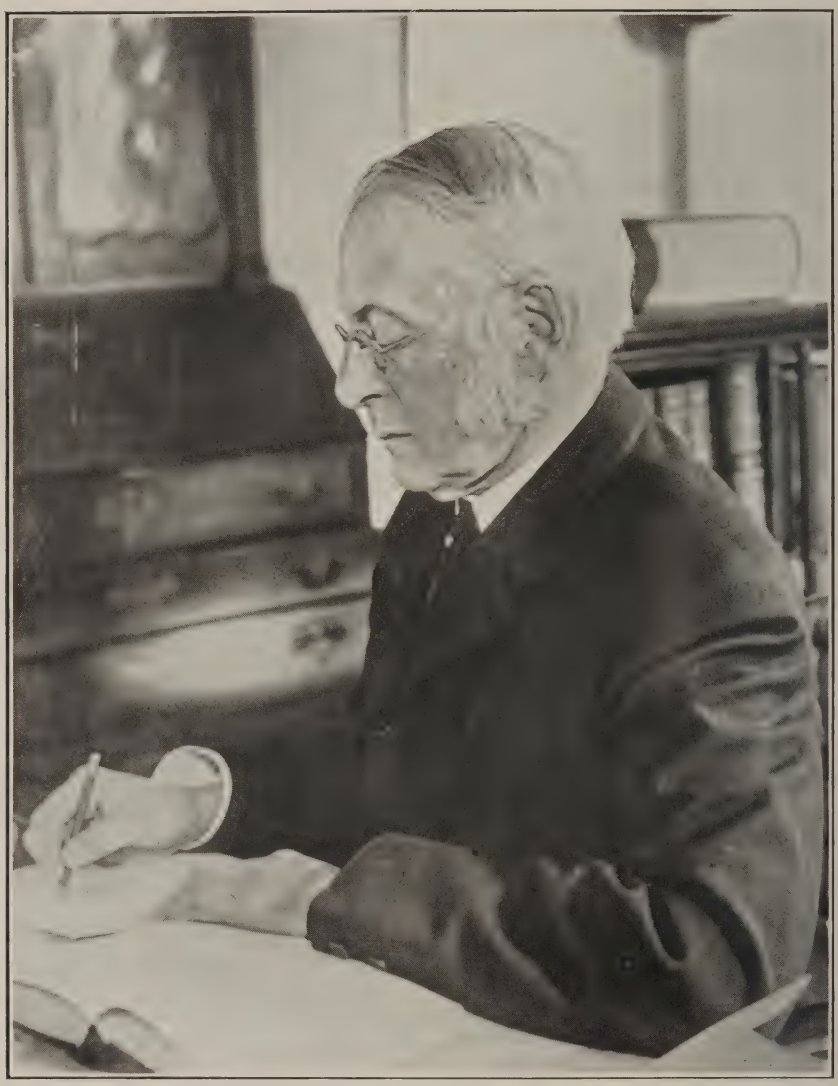

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MENTAL HYGIENE

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FREUD'S IMPORTANCE FOR THE MENTAL-HYGIENE MOVEMENT

WRITTEN ON THE OCCASION OF HIS SEVENTIETH BIRTHDAY

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Budapest, Hungary

IT IS with great pleasure that I accede to the kind request of Dr. Frankwood Williams to say something about the possible relations between the mental-hygiene movement and the psychological and therapeutical method originated and developed by Freud and called psychoanalysis. For a long time I have been convinced that the importance of those relations has, generally speaking, been too little appreciated. The literature of psychoanalysis has been concerned chiefly with the investigation of neuroses, from which it obtained all its new knowledge. Although this knowledge has at times been applied to the psychoses also, the analysis of the psychoses has remained only applied psychoanalysis, as it were; it has not developed into an independent source of knowledge.

It may nevertheless be asserted that psychiatric science has profited much by the analytic point of view. Before Freud's time psychiatry was not based on psychology. Attempts were made to ascribe the symptoms of mental disease to anatomical changes in the brain. But such attempts were only half successful and then only in connection with certain deficiencies in severe organic lesions of the brain (psychotic disturbances in cases of brain tumors, multiple sclerosis, after repeated paralytic strokes, after inflammation of the brain, and in cases of progressive paralysis and senile dementia). All the

so-called functional psychoses—mania, melancholy, paranoia, dementia praecox, and hysterical psychosis—remained inexplicable from an anatomical point of view, however much one tried to prove that specific microscopical changes took place in those disorders. The expression "functional" served merely to veil our ignorance. How could we have been able to give the slightest explanation of the pathological change in the function of the psyche when we did not know anything about its normal function? Instead of remembering that fact, the authors of psychiatric manuals indulged in fancies about invisible cellular and even molecular changes, which were supposed to be at the bottom of the psychoses. Not one psychiatrist thought of looking for psychological explanations of the psychotic symptoms.

Holding those settled views, they took of course very little interest in the psychic contents of the acts and expressions of insane persons. These appeared to them to be merely unessential phenomena, attendant on the supposed molecular or functional change in the organ, which, at most, they used as a means for diagnosing the case or giving it the proper label. The psychic performances of the diseased were marked as "confused", "disconnected", "mannered", "stereotyped", "fickle", and even as "incoherent" and as "verbal salads", and were shown to students and visitors of insane asylums almost as if they were curiosities.

The influence of psychoanalysis has brought about fundamental changes in this field. Freud taught us that the "psychoses" manifest themselves not simply as the consequences of a psychic "shock" (which idea was still based, though not admittedly, on the analogy with physical trauma and concussion of the brain), but that their symptoms are the final result of an inner psychic struggle between opposing tendencies. That inner struggle, which in neurotic persons ends in "repressions" (*Verdrängung*) and the formation of neurotic symptoms, is something that so-called normal individuals may also observe directly in themselves by pure introspection. The consequence was that in the first place the neurosis was made accessible to introspective investigation and to therapeutics, and secondly that the partition wall which had been thought of as dividing healthy from neurotic

individuals disappeared. Further progress of the investigation showed that the wall separating neurosis and psychosis must also be torn down and that even the most singular acts and mental processes of the insane are to be reduced to psychic conflicts, analogous to those which exist in "normal" individuals, too. The conduct, too, of insane persons ceased to be senseless and their expressions ceased to be "verbal salads"; the skilful interpretation of their contents created the possibility of relating even the most scurrilous and confused words of the insane to those frequently tragical conflicts which are understandable by all of us.

The mental activity the psychic analysis of which completely removed the chasm between insanity and mental health—which had hitherto been thought unbridgeable—was the activity of the psyche *in dreams.* Even the most normal individual is in a sense psychotic during the night; he has hallucinations; his logical, ethical, and æsthetic personality is completely changed in most cases in the direction of greater primitiveness. Formerly science consistently explained the dream also as an insignificant phenomenon accompanying molecular or other changes of the brain during sleep. But when *Freud interpreted* the first dream—*i.e.,* made it understandable in spite of its senseless make-up—the statement that the sane and the insane could not be compared had to be dropped. The fact that all of us recognized in ourselves the possibility of performing the psychic acts that we call insane was immensely important for the treatment of the unfortunate victims of insanity. The psychiatrists began to pay attention when the insane individual said or did something strange; they began to interpret his conduct and to search for comprehensible associations between the disconnected words of his flow of thoughts; they tried to recognize in the shapes of his visions, in the voices of his auditory hallucinations, the pathogenetically important persons of his life's history. It was by this step that psychiatry freed the insane from their tragic isolation. If the humanitarian spirit of the nineteenth and twentieth century did in fact relieve the insane of their chains and drag them forth out of their cells, of what avail was it if they were to remain as before mentally isolated and misunderstood? It was only after their expressions, too,

became recognizable as representations of general human tendencies—*i.e.*, after we began *to understand the language of the insane*—that the latter really were accepted as members of human society.

As far as I am informed, one of the main objects of the mental-hygiene movement is to better the lot of the insane, to facilitate their return to ordinary society. The hope exists that psychoanalytical investigation, by penetrating still deeper into the mechanisms of these forms of disease, will in time produce results in the cure of psychoses similar to those which in our days have been produced in the treatment of the psychoneuroses (hysterias and compulsion neuroses). In any case psychoanalysis is at present the only practicable road to the understanding of "functional" mental diseases, and that understanding could even to-day contribute much to the improvement of the condition of the insane. I therefore think I was right when I asserted at the beginning of this article that there are bonds of relationship between the aims of psychoanalysis and "mental hygiene". Ways and means should be found to promote those common aims by coöperative exertions, and that will also be the most dignified manner of celebrating the birthday of the scientist who made such progress possible.

Coöperation might take two forms: some of the most experienced analysts should be given an opportunity to devote themselves for a lengthy period to the study of psychoses in sanatoria, and scholarships should be founded for physicians attached to institutions, to enable them to make use of the facilities available for psychoanalytical training.

THE MENTAL FACTOR IN THE ECONOMIC ADJUSTMENT OF 500 DISABLED EX-SERVICE MEN

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ONE of the most important of the problem groups that have arisen since the war is that of the mentally or physically handicapped who are not ill enough to be permanently institutionalized, yet apparently are not well enough to readjust themselves to normal economic and social life unaided. The mentally handicapped of this group are particularly a problem; the increasing number of psychoneurotic and psychotic individuals at large is assuming an alarming significance, especially since their maladjustments are taking not only the negative expression of non-productivity, but more and more that of positive antisocial behavior.

Because of the increasing number of experiments in treating this group and the growing interest in them, I am recounting my experiences during a year's work in Chicago as secretary of an employment bureau for disabled war veterans. This bureau was established by the Chicago Woman's Club, as a result of a survey it had made of the agencies in the city that deal with ex-service men. Practically all of these agencies had emphasized the need of a skilled employment service for handling the specially difficult cases.

In the year that followed, our bureau handled in detail 500 disabled men, all of whom were considered special problems. That is, they had been dealt with by various governmental and private agencies since the time of their discharge from army hospital or camp without effecting a successful readjustment into civil life.

Out of the 500 men, 266 had been referred to the Neuropsychiatric Section of the United States Veterans' Bureau and had been diagnosed as having a neuropsychiatric condition,

which, if not the sole disability, was at least the predominant one. Since the first-comers to our bureau surprised us by belonging entirely to this latter group, the question immediately arose as to the advisability of handling them by methods distinct from those planned for the purely physically handicapped with whom we had largely expected to deal. However, it very soon became apparent that even those men with predominant physical handicaps who had never undergone an examination by a psychiatrist were suffering *much less from a physical inability to adjust to a job than from a mental inability to adjust to their handicap.* The few men who were obviously without any mental abnormality, even where their physical disabilities were exceptionally severe, were so easily dealt with that they hardly entered into the problem.

The most difficult disability, for instance, from an employment standpoint, for the man of average seventh-grade education, is an arm amputation. Yet we had one one-armed man who had for over a year worked as bell boy and later as bell-boy captain in one of the larger hotels, who had spent a summer as private chauffeur—a job that entailed at least two trips daily through the thick of downtown traffic—and who had left that work only to enter a more responsible position.

We had a man with an amputation from the thigh who had satisfactorily adjusted himself into a position as driver of a delivery truck. During an inter-seasonal slackness, we found him the job he wanted—that of private chauffeur. We had another man with an amputation of two fingers who, although he had recently had vocational training as mechanic and chauffeur, absolutely refused to accept work as chauffeur, because of his handicap.

We had a man with a double hernia, a salesman by trade, who professed himself absolutely unable to hold a job in any sales line because of his disability and the occasional necessity of carrying sample cases. We had others who, with the aid of the same prosthetic appliances he used, were able to carry on successfully as auto-mechanics or farmers. We had a man with a valvular heart condition who refused a job as stock clerk, as being too heavy. He later rehabilitated himself at his pre-war occupation, as teamster on an ice wagon! We had a number of men who professed to be unable to work on such

short time as the three-hour shifts for counter men or dish washers in restaurants because of a second degree *pes planus*. We had other men with a gun-shot wound or arthritic condition of knee or ankle who were able to parallel very closely the work of physically sound men. Even in such an extreme case as an aortic aneurysm, the patient finally rehabilitated himself as bootblack on a small stand in his neighborhood.

It became evident, therefore, that the bulk of our work would have to be not so much in mere job placement of physically handicapped men, as in the more hazardous attempt at what might be termed general psycho-economic adjustments.

Our first concern was to discover whether there was any one generally applicable factor that underlay the maladjustments of the men who came to us. If it was not the physical disability *per se*, was it the neuropsychiatric condition, or was it some other underlying factor, such as foreign nationality, lack of education, lack of training, subnormal intelligence, family burdens?

The physical disabilities of the 500 men were as follows:

Gun-shot wounds	—arm, hand, leg, foot, abdomen, knee, back, neck, side.
Amputations	—one to four fingers, thumb, leg, two or three toes, arm.
Ear disabilities	—partial and total deafness, otitis media.
Eye disabilities	—partial blindness, myopia, hyperopia.
Unclassified	—broken wrist, loss kneecap, leg tumor, varicose veins, osteo-arthritis knee and ankle, *pes planus*.
Internal diseases	—chronic bronchitis, arrested tuberculosis, pleurisy, empyema, arthritis, rheumatism, articular rheumatism, nephritis, sinusitis, valvular heart disease, endocarditis, myocarditis, mitral stenosis, aortic aneurysm, venereal disease, goiter, hyperthyroidism, enteroptosis, post-operative adhesions, hernia, duodenal ulcer, varicocele, malaria.

From the standpoint of employability, some of the men with the above disabilities might seem almost hopeless. Yet, contrary to my own preconceived theories, I can recall hardly an instance in which a man was entirely unemployable because of his physical disability.

The post-war histories of the men elicited an astonishing variety of trades, a few of which are given below in connection with the physical disability represented. No occupation is listed which had not been carried on for an approximation of at least three months:

Hernia	—auto-mechanic, sole-leather worker, machinist helper, teamster, farmer.
Arrested tuberculosis	—lawyer, electrician, salesman, clerk, punch-press operator, patrolman, chauffeur, wood scaler, timekeeper, elevator operator, auto-assembly worker.
Arm amputation	—salesman, messenger, doorman, watchman, proprietor cigar stand.
Leg amputation	—chauffeur, drill-press operator, clerk, shoe repairer, gardener, elevator operator.
Abdominal injuries	—pencil-machine operator, kitchen helper, insurance agent, bookbinder, salesman, molder, conductor, carpenter, baker.
Valvular heart disease	—clerk, conductor, teacher, teamster, tool-grinder, watchman, flagman, inspector, salesman, electrician, janitor.
Mitral stenosis	—sole-leather worker, accountant, elevator operator.
Total deafness	—stock clerk, assembly worker, auto-mechanic helper.
Nephritis	—mechanic, salesman, floor-walker, farmer, punch-press operator, butcher.

This does not mean that such trades were necessarily advisable or advised. It merely means that in an emergency they were and could be carried on and that the medical records did not show any acute condition as a direct result. The undertaking of work unsuited to the physical disability was of course a factor in the man's problem, but concrete findings indicated that it was hardly ever the determining one.

The 266 men diagnosed as having a neuropsychiatric condition are listed below, together with a tabulation of the results of our efforts in placing them, which will be referred to later:

Neuroses	*Total*	*Failure*	*Institution*	*Satisfactory adjustment*	*No record*
Nature undetermined	23	2	..	9	12
Neurasthenia	32	11	..	13	8
Anxiety	17	4	..	7	6
Hysteria	14	5	..	4	5
Psychasthenia	6	1	..	2	3
In combined forms	13	2	..	6	5
With mental deficiency	19	9	3	6	1
With psychopathic inferiority	23	8	..	9	6
With mental deficiency and psychopathic inferiority	6	3	..	1	2
	153	45	3	57	48

Psychoses	*Total*	*Failure*	*Satisfactory*		
			Institution	*adjustment*	*No record*
Nature undetermined	2	..	..	2	..
Dementia praecox, simple	11	3	2	5	1
Dementia praecox, hebephrenic	6	3	..	1	2
Dementia praecox, paranoid	4	1	..	..	3
Manic-depressive	2	..	..	1	1
Psychosis with mental deficiency	4	2	1	1	..
Paranoia with psychopathic inferiority	6	2	2	1	1
Dementia praecox with psychopathic inferiority	2	1	..	1	..
	37	12	5	12	8
Epilepsy					
With deterioration	3	1	1	..	1
With psychosis	1	..	..	..	1
Hysteric	2	1	..	..	1
	6	2	1	..	3
Alcoholism					
Without other factor	1	1	..	..	..
With hysteria	2	2	..	..	..
With hysteria and mental deficiency	1	1	..	..	..
With psychopathic inferiority	2	2	..	..	..
	6	6	..	..	..
Mental deficiency					
Without other factor	33	16	2	10	5
Psychopathic inferiority					
Without other factor	22	14	..	3	5
Mental deficiency and psychopathic inferiority	7	4	..	1	2
Loss of memory	1	..	1	..	..
Paresis	1	..	..	..	1
Total	266	99	12	83	72

In these 266 cases, there were 66 different diagnoses. Of those with combinations of neuropsychiatric conditions, there were 69 cases in which mental deficiency was a factor, 68 in which constitutional psychopathic inferiority was a factor, 55

with a neurasthenic factor, and 44 with an hysteric factor, of which 14 were hysteria alone. There were 31 with an anxiety neurosis, 17 of them without other factor. There were 23 with dementia praecox and 10 with a paranoid factor, 6 of these combined with psychopathic inferiority. There were only 6 cases in which alcoholism was a factor.

Most of these men had some physical disability associated with their mental condition and it was, moreover, to a physical handicap, whether major or minor or non-existent, that all of the men ascribed their inability to work.

The more general information obtained from the histories of the men is tabulated briefly below. In order to ascertain whether the neuropsychiatric group, as diagnosed, varied from the group as a whole, figures are given for both.

National and Racial Factors

	Entire group (500)	Neuropsychiatric group (266)
Native white	324	179
Colored	41	18
Polish	40	26
Italian	23	10
Russian-Jewish	17	10
British	13	2
Balkanian	8	4
Scandinavian	7	3
Lithuanian	7	3
Bohemian	5	3
Persian	4	2
Slovakian	3	2
French	4	1
German	3	2
Filippino	1	1

The great bulk of the men were native white. The Polish group, in comparison with the Italian and Russian-Jewish, was, according to recent immigration statistics, somewhat disproportionately large. But none of the foreign groups were large enough or homogeneous enough to constitute a problem in themselves.

Civil State

	Entire group (500)	Neuropsychiatric group (266)
Single	268	155
Married without children	100	49
Married with children	132	62

The men were slightly below the average in marital statistics, but the fact that most of them had been in and out of hospitals a great part of the time since discharge from the army might account for this. In practically every instance where there was a marriage without children, the man's wife was employed.

Education in the United States

	Entire group (500)	Neuropsychiatric group (266)
None	70	39
One-half year	12	4
1st grade	9	3
2nd grade	8	8
3rd grade	5	5
4th grade	11	8
5th grade	27	18
6th grade	35	24
7th grade	51	28
8th grade	138	70
1 year high school	32	13
2 years high school	21	11
3 years high school	10	4
4 years high school	45	18
1 year college	8	4
2 years college	12	4
3 years college	2	2
4 years college	3	2
Post-graduate	1	1
Average grade	6.9	6.6

This average grade closely approximates the 7th-grade average of the general army draft. Intelligence tests—the Stanford-Binet, the Army Beta, the Stenquist mechanical ability, and several special-aptitude tests—were made of 60 of the men, chosen at random from the group. The average mental age proved to be 12, which also approximates the average of the general army draft.

Special Vocational Training since Service

	Entire group (500)	Neuropsychiatric group (266)
Number of men with vocational training	259	136
In line of pre-war occupation	37	16
In a new line	213	117
In both pre-war and new lines	9	3

Most of this training was carried on under the Rehabilitation Section of the United States Veterans' Bureau. In view of the fact that such training for handicapped men, both under public and private auspices, has recently been widely advocated, the tremendous experiment made by the government should rightly have received more general attention than it has to date. The question as to whether it is possible to train or retrain adult men of average intelligence and education on a large scale is one with wide economic implications. Whether this has been done or could have been done by the Federal Government is a matter that has as yet received little study from without, and it deserves much.

Since all men with a service-connected disability at least 10 per cent disabling were entitled to vocational training, unless the disability were so severe as to render training not feasible, our 259 ex-trainees constituted the center of our problem group. The post-training occupations undertaken by these men are given below, with the results indicated under the various column headings. For purposes of comparison, the figures for the 136 neuropsychiatric cases are given as well as those for the entire group.

	Total		*Satisfactory adjustment*		*Failure*		*No record*	
	Entire group	Neuro-psychiatric	Entire group	Neuro-psychiatric	Entire group	Neuro-psychiatric	Entire group	Neuro-psychiatric
Occupation in line of pre-war trade ..	34	19	19	10	6	4	9	5
In training trade	52	21	27	10	7	6	18	5
In new trade....	107	56	49	22	20	16	38	18
In pre-war, new, and training ..	29	15	..	7	7	7	11	1
No occupation	37	25	..	..	..	..	..	..

Of the 259 men, 27 were known finally to have made satisfactory adjustments in the trade for which they were given vocational training, 10 of these being diagnosed neuropsychiatric cases. By far the greatest number of men attempted a new trade and a little less than half of them were successful in it, as compared with the satisfactory adjustment of a little

more than half of those who entered trades wherein they had had previous experience.

Almost 90 per cent of the ex-trainees, therefore, who came to us, were unable to make any use of their training. Whether this was because of faulty training or because the men were those who could never have benefited by any training had to be individually determined. It must be remembered, too, that we received only the most difficult cases, those who had become cumulative problems during the preceding four years.

According to the information given in the above tables, there was apparently no one factor that appeared constantly in the problem of the man's maladjustment, whether this maladjustment was evidenced in a psychosis, a neurosis, or merely in a temporarily unadjusted state such as any normal individual might experience after prolonged hospitalization or a severe upheaval in his habits of living. There was, furthermore, no direct relation between the severity of the mental maladjustment and the factors of physical handicap, lack of education, foreign birth, and so forth, which might presumably act as complications. There seemed also to be absolutely no relation between certain kinds of neuroses or psychoses and correlated possibilities of adjustment. A neurasthenic might be more difficult to place than a dementia praecox in remission. An hysteric might be the hardest to place of all, or he might be one of the easiest. It was equally impossible to establish any consistent correlation between trades and either physical or mental disabilities. In discussing, for instance, possible trades for cardiac cases, the physicians stressed the fact that the degree of compensation in valvular heart disease meant quite as much in determining the man's trade as did the disease itself. This was equally true of psychic compensation for either somatic or psychic injury, and had always to be individually determined.

In general, however, we found two persistent characteristics evidenced in the men who came to us: a loss of self-reliance and an apparently concomitant loss of sense of responsibility. These, more than anything else, determined the acuteness of the man's economic problem. They seemed, moreover, to have much less relation to the man's neuropsychiatric condition than *to the way in which this condition had been handled.*

There were physicians who still believed in the strait-jacket sort of treatment for even the mildest disorders. There were social workers whose desire to mother the world had led them into an assumption of protectiveness hardly less than that so generally denounced now when practiced even on the smallest children. Between these two extremes of attitude lay all grades, both on the part of professional psychiatric workers and on the part of the layman who generally gets the blame for maltreatment.

A number of the industrial and social histories of our men, particularly of those coming in during the month of January, when most of the casual-laborer group of the Middle West converges in Chicago, showed the men always to have been irresponsible drifters of the constitutional psychopathic type. With these men our most prolonged efforts seldom produced a satisfactory adjustment—that is, one that evidenced signs of permanence. But a great number of our men had been steady workers and responsible members of society before the war and were often more demoralized by post-war treatment than by the war itself. Most of the men in the more chronic states of neuroses would give the information at once that they had been able to do no work since the war. But in a surprising number of cases, very careful inquiry elicited the information that they had gone to work immediately after discharge from the army and had stopped when they found that they could get vocational training or more compensation. It was this stormy period of constant dwelling on aches and pains for the purpose of more compensation and of trying to be reëducated in trades that were ill-fitting that seemed often to be one of the real causes of demoralization. Chronic illness usually lessens the sense of responsibility toward others. Re-schooling, in wrong subjects with inadequate preparation, may lessen any man's self-reliance.

Practically all of the men who came to us were in an almost childlike state of dependence, and before placement was even to be thought of, this attitude had to be combated. This was by far our biggest and most difficult task. Once the man really believed that he was able to work, that he should work, and knew what kind of work he wanted to do, the actual placement was relatively effortless. In fact, once these difficulties had

been overcome, in the majority of cases the man could practically place himself.

As stated above, the severity of the man's disability seemed to have little relation to the difficulty of adjustment. There was a much more direct correlation between the concreteness of the handicap and the ease of solving the problem it caused. A man with one leg or one arm knew exactly where he stood. A man with pains and aches indefinitely located and with a queer feeling in his head was usually at least as much at a loss as most of the people who tried to treat him.

As illustrations there come to mind two cases, one of thigh amputation, the other of neurasthenia following a healed gunshot wound of the shoulder. Both men were Polish immigrant laborers. Both had seen active service in France and both had been wounded. Readjustment afterwards was, however, apparently in direct contrast to the degree of severity of the wound.

Anton had had his right leg amputated from the thigh. He had been a butcher before the war. After his discharge from service he was given vocational training—in bookkeeping. Bookkeeping was a standard opportunity offered to men who needed to learn a sedentary trade.

Anton, being a butcher by temperament, inclination, and long-formed habit, did not take to bookkeeping. He was finally discontinued as unable to benefit by further training, turned into the world with his stump leg, his fifty dollars' monthly compensation, and a disposition by no means pleasant. He was eventually referred to us.

After obtaining the necessary preliminary information from him, we took up the subject of vocations, going carefully through our list and explaining each trade in detail. In one or two of these he showed a glimmer of interest which quickly disappeared when he learned that he could not possibly, until he had had a considerable number of years' experience, earn as much by them as he had as a butcher. At this trade he had earned from $35 to $40 a week before the war. He knew that such work was out of the question now, but he was equally certain that he had to earn an equivalent wage and the fact that he could not do so as a bookkeeper was one of the most important causes of his lack of interest in that line. We

brought up the point several times that his monthly compensation was given to compensate for his decreased earning power, but made little impression. He wanted to work and he wanted to earn $35 a week, and his slow, uneducated mind was unable to adjust to any compromise. The fact that the inability was a result of unwillingness, that the mental stubbornness had an emotional root, made it much more subtle and difficult to treat, but not less real. Neither persuasion nor suggestion were or would have been of much avail. They had already been tried for the past three years, with much wear upon the dispositions of all concerned, but without other result.

The real difficulty was that, with the best of intentions, a hard-working, financially substantial, if somewhat stupid citizen before the war had, by its inadvertence, been remade into not only a physically handicapped, but a mentally dependent man. From the time of his amputation to the time when he came to us, he had apparently not been forced to decide anything for himself. For nearly four years, the only thing he had done was to go to school, which, for a man of such mentality, would not fit into his concept of adult life. Far from being adjusted to his present handicap, he was probably in a worse condition mentally than when he first left the hospital in France.

Having been unable to reach any solution in our interview with him, we told him to go home, to think over the facts we had given him, and to return the next day to talk them over with us again. We quite often gave this advice, as the results of it were illuminating. If the man were getting enough compensation and assistance from friends or relatives to live on and had come to us because he was sent or accompanied to our desk, but did not really want work, he very seldom returned after the first interview.

However, Anton returned promptly. He had not had a change of mind, but he seemed to think that if he persisted, he could argue us into giving him the kind of job he wanted. Questioning revealed that he still did not know himself what kind of job that was. He reverted again to his pre-war trade and his need to earn the amount he had made at it. For another hour we reviewed the list of all trades which were at all within his scope, but got nowhere. We then told him quite

definitely that we had no other suggestions to make and that all further decisions in regard to his actions were entirely up to him. We explained carefully that his compensation was on a permanent partial basis and that there was practically no chance of its being altered. We also explained very carefully the ruling which excluded him from further chance of vocational training. We made these explanations as detailed, as emphatic, and as final as possible and repeated them until they really seemed to have penetrated.

Anton, who had some time since ceased his petulant arguing, listened to us quietly and with surprising attention. Then he left us quietly, without making any promises.

About three weeks later he returned to tell us that he had a job and that he was earning $30 a week. The job was that of butcher! He went on to explain. After talking to us, he had decided to let all this fuss with the government drop and really get to work. He had also decided that he had to earn around $35 a week and since he could not do this at anything but butchering, he would return to that. After about a week's careful investigation, he had found a place where the work would not be too heavy, where he would be given the lighter cuts, and where he could have a barrel to sit on. Things were going splendidly; he felt not only as well as he had, but better, and as soon as he had worked into the trade again, his wages were to be increased.

Anton's case well illustrates my conclusion that the therapy of what I might call positively motivated discipline is all that a number of such men needed.

Steve, although with a minor physical disability, was in many ways in worse condition that Anton, because of his greater mental handicap. He also had the additional burden of a wife and two small children. The examination by the psychologist gave him a mental age of 11 years, 6 months. Physical and neurological examinations gave him a healed gun-shot wound of arm and shoulder and neurasthenia.

Just why his original induction into vocational training after the war had been in the line of bookkeeping no one was able to discover, but through sheer helplessness as to what else to do with him, he had been kept in the same line. Being a foreign laborer with little education and subnormal intelli-

gence, he found this, of course, a great tax on his powers of adjustment. That he developed no other mental disorder than that of neurasthenia spoke rather well for his equilibrium than otherwise.

When he came to us, he had been pronounced not fitted for further training; he had not shown a coöperative spirit in such placement as was offered, and had therefore been left to his own resources.

From the beginning it was evident that his problem needed an entirely different mode of attack from Anton's. Telling him to think for himself at that time would have been useless. Before even considering permanent placement for him, a basic reconstruction of his entire mental attitude had to take place.

After lengthy interviews with him and with all the people who had been dealing with him, officially or unofficially, our first action was to relieve immediate economic pressure by temporary placement. Through the manager of the local office of the Veterans' Bureau, we found a place for him in the filing section. His sole duty was to pull folders out of the files when these were requested. He did not view the work sympathetically and he did not believe that he could support his family on the salary, but being persuaded that it was better than nothing, he took it.

During the next three weeks, he failed to appear for work on an average of three days a week. The cause was a pain, variously located. As often as possible after these absences, he was taken to the examining physician, who was invariably unable to discover any physical cause for the pain. Our persuasions toward resumption of work followed and Steve would try again—for two days.

Finally he came to us and said that he had lost his job. He did not know why, but seemed to feel rather badly about it. Inquiries elicited the expected. The Veterans' Bureau was unable to keep a man on the pay roll, even as a temporary substitute, unless he could work. We explained this again to Steve, very carefully, and finally he grasped a tremendous new fact: that his work had to be done and that it was not done unless he were there to do it. This may sound amusing, but it was a matter brought up time and again by employers. "If

these fellows who drop their work for so many excuses could only realize", they would say, "that if there isn't some one there to do the work, there won't be any work to do."

We repeated this to Steve. "Stay till you drop", we told him. "And if you drop, there are a dozen doctors in the office to treat you and an ambulance downstairs to take you to the hospital. But the work has to be done." Another consultation with the same physician who, as an individual, had won Steve's confidence, followed. As a result Steve was given another try and did not miss a day's work for two weeks. Of all who were surprised, there was none so surprised as Steve himself.

The rest was fairly simple. An afternoon's conversation revealed the fact that Steve, despite several unsuccessful attempts, still believed he could do better at the stockyards, where he was before the war—and, a hitherto carefully submerged fact, immediately after the war—than anywhere else. Within a week we had him placed there, as checker of ice cars. A couple of months later he came into our office to inform us that although it was at times painfully hard, he was still there. For the first time in four years he was really supporting his wife and children and showing signs of being again a productive citizen.

Another protracted problem was a man with a valvular heart condition, plus an anxiety neurosis. He was a well-educated, prepossessing young man with a nice wife and quite high standards of living. His vocational training had been in general clerical work. When he came to us, with the immediate prospect of being rehabilitated on a $20-a-week job, which even with his compensation would not carry him, he was in an almost dangerous state of anxiety and depression.

After the usual lengthy interview with the man, we talked with his training officer and with the employer who had had him under direct supervision. Both assured us that he was not possibly worth a higher salary and that he would probably have difficulty earning that much. To settle the possible question of mental deficiency, our psychologist gave him the Stanford-Binet test—with a resultant I.Q. of something around 115! We then gave him the special-aptitude test for clerical workers. The average result for this is C. His combined

results were B—. Greatly puzzled, we took the matter up with the Vocational Training Section of the Veterans' Bureau, which finally agreed to postpone the date of rehabilitation from training a few weeks. Meanwhile he also was put in the filing section of the bureau, on a low-salary basis.

In the series of interviews that followed, we told him frankly of the conflict in the report from his training employer and that from the psychologist. We also went into his nervous disorder with him, which consisted not only of his constant inner anxiety, but of a very evident stammering and lack of continuity in his speech. We reviewed his difficulty from every angle, including his home and marital relations, his pre-war work and educational history, and the events of his post-war life. But the cause remained obscure. However, the noticeable thing was that from the moment we informed him of his high intelligence quotient, there was an improvement in his speech. The work in the filing section removed immediate cause of worry and, I believe not least important, our continued insistence that he *decide for himself* what he would really like best to do, if further training could be obtained for him, gave him something positive to think about.

He thought about it, intelligently and seriously. He made inquiries outside, in various offices and schools. He finally stated definitely that he would like to be a teacher in a business college. He had done some general teaching before the war in a country school and liked it. He could, after a year or so of experience, earn a salary of $200 a month, or even more.

Because he had so nearly approached the four-year limit of vocational training with pay, he had to take it without pay. This meant that he continued to work during the day and studied at night. The remarkable fact was that this man, who had apparently been so ill and nervous that he could not do an ordinary day's work, now worked both day and night and benefited by it. His general physical tone was much better. His stammer practically disappeared, and he lost entirely the bashful manner and inconclusiveness of speech which had acted so to his detriment. About three months later he found himself a post as instructor in a small business college upstate, at a beginning salary of $125.

An example of the numerous men who came to us with temporary nervous disorders may be cited in the instance of a man who had been hospitalized for tuberculosis off and on for several years. He was finally discharged as being a quiescent case and in good condition, much against his own convictions, and, after he had drifted around a while in a very depressed state, was referred to us. He was a Polish man of a rather high type and was well-educated, but our first interview with him was almost impossibly difficult due to the fact that he threatened to burst into tears at every question. He was so palpably ashamed and so thoroughly depressed that we soon ended it and, without knowing very much about him, suggested that he might be interested in an opening in a real-estate office run by a former client of ours, another Polish man. We told him to think it over and let us know later. We also got in touch with the real-estate office and explained the man's condition.

In a few days he returned and mournfully asked for the address of the office, although he doubted he could sell anything. Only three days later he returned again, with an appearance of such normal competency that at first we did not recognize him. He explained that he was selling lots to Polish people in a new subdivision near the steel mills. His first customer had netted him a commission of $28, and he had other immediate prospects! May I add that no even semi-orthodox interview was ever taken of this man, nor did it ever prove necessary. Here was a nervous condition caught, by mere chance, at the very beginning.

At the other extreme stood our young dementia praecox who could not wake up in the morning. He came to our office daily, about 11 a.m., for perhaps three months, asking for a job. He was receiving total compensation from the government and his case was therefore not emergent, employment being recommended purely for therapeutic reasons.

His only possible line was in unskilled labor, such as loading trucks or the like, and he was willing to do this, but by the time he arrived at the employment offices the jobs were invariably taken. Daily, therefore, for three months, we explained to him that he could not get a job unless he got there early. At the end of the three months he disappeared. Four months

later he returned and informed us that he had been working ever since his last visit to us. He had gone to a store to which we referred him, had been the first one there, and had got the job. He had saved practically all of his earnings and had now decided to take a vacation.

Persistence also won with another of our men, a very unprepossessing, insignificant little Italian, with an anxiety neurosis and a subnormal intelligence. Day after day he haunted our office, not knowing just what he wanted to do, but willing to take anything if the employer offered it to him. These were the winter months when the over-supply of migrant labor in Chicago is thickest, and jobs were not being formally offered to any one. One lead, however—that to the Yellow Cab Manufacturing Plant—interested him especially, for an unknown reason. After visiting it, he decided that he would work there and resolutely returned to its employment office every morning for three weeks, at the end of which time he was taken on in the plant as a permanent worker.

Mr. W———, a manic-depressive in remission, who had been a scientist before the war, is an excellent example of the kind of man who needed only a few hours' interview before he was able to rehabilitate himself. After giving us his more general history, he talked at length of his pre-war work, in which, because of its delicate manipulations, he was utterly unable to continue. He also described the many post-war ventures which, by their failure, had robbed him of what little income or self-confidence he had. Even his attempt at suicide had failed. Yet, despite his high intelligence and training, the question, "What do you really want to do?" seemed to surprise him as much as it did most of the men. Then, in the same rather shy, rather eager, and rather pathetic way many of the men used in unfolding their secret and seemingly impossible plans, he told us that what he would really like above all things to do was to return to his own profession, but to go into it from the selling rather than the laboratory end. He had never even considered trying it because he was not a business man, knew nothing of salesmanship, and would automatically not qualify.

But the mere fact that he had discussed it seriously with some one cognizant of the general business situation was ap-

parently enough. At the time he gave us, upon our request, the names of three firms in the city dealing in his specialty and we said that we would get in touch with them for him if he wished. But a few days later he wrote us that he had contacts with one of them himself and was now satisfactorily employed —as a salesman.

May I repeat again that once a man knew that he really wanted to work and what he wanted to work at, he was no longer a failure. Until he did, he was. A young man with an hystero-anxiety neurosis, who tried factory work, then night-watchman work, must have tried fifty jobs before he finally found what he wanted and kept it—a position as post-office clerk. A totally deaf man, who had been given training in dentistry, but who decided that he did not like it, was placed in an electrical plant, where he made good. A practically blind man had somewhere received training in massage and liked it. Through his own persistent efforts he was finally taken on in the physio-therapy department of the Veterans' Bureau and made good.

From these few examples it will be seen how impossible it would have been to attempt to regulate a man's trade by his disability. In fact, in considering possible vocations, the sooner emphasis could be removed from the disability, the better for the man and his chance of success. Like every one else, he had his own special abilities and handicaps and his only salvation lay in not being treated as a classified unfortunate.

The general results of the year's work may be summarized briefly, as follows:

	Entire group (500)	Neuropsychiatric group (266)
Satisfactory adjustments	170	83
Permanent institutionalization	20	12
Failures	112	99
No record	198	72

"*Satisfactory adjustment*" means that the man was placed in a position which suited him, and that, in the course of as much follow-up work as was feasible, he gave every indication of remaining there. As will have been noted in the examples given, the term does not necessarily mean that we found

the position for him, although we made contacts in all with 2,503 positions.

"No record" means that the man did not return to us or any other discoverable agency.

There were twenty men who, after experiment, proved absolutely incapable of grappling with society because of advanced physical or mental disorders and for whom institutionalization or home care was recommended and obtained.

If, after working with and for a man, he definitely remained unadjusted, to our knowledge, despite every effort to adjust him, he was listed as a failure. Of the 112 men so listed, all but 13 had a definitely diagnosed neuropsychiatric condition.

The results of our work with the neuropsychiatric group are given in more detail in the summary on pages 680–81. If the figures quoted may be considered of any value, being, as they are, usually only an approximation, it is in demonstrating the reiterated statement that a man's economic adjustment or maladjustment was not determined, in the majority of cases, by his particular kind of neuropsychiatric condition. A man's mental outlook had everything to do with his success or failure, but the particular clinical type of his mental disorder apparently little.

Of the psychoneurotics, 45 were termed failures and 57 were supposedly satisfactorily adjusted. At little less than one-third of the neurasthenics were failures, and a little more than one-third reached adjustment. The hysterics were about evenly divided. Of those with an anxiety neurosis, there were 7 adjustments to 4 failures.

Seven out of 23 men with psychosis without mental deficiency or psychopathic inferiority were definite failures (the other 2 of the total 25 having been institutionalized). Seven left no record and 9 were satisfactorily adjusted. Of the 12 psychotics with mental deficiency or psychopathic inferiority, only 3 made adjustments, while 3 were institutionalized. Of course, those men with a psychotic condition who were sent to us were usually in such a state of remission that the physicians thought it safe to recommend work and some of them were able to make excellent adjustments.

Among those with mental deficiency, with or without other factor, the percentages of failures were always somewhat

greater. The most marked difference, however, was with the constitutional psychopaths where, without other factor, there were 14 definite failures against 3 approximate adjustments —2 of these adjustments being the induction into vocational training—and with the alcoholic group, all 6 of which were definite failures. The alcoholic group was almost too small to permit of generalizations. Our experience with the psychopathic-inferior group is well described in an observation by Dr. White on the psychopathic constitution: "those ill-balanced, eccentric individuals who may be superficially brilliant, but lack continuity of purpose and capacity for the continuous expenditures of effort in any one direction". If the constitutional psychopath constitutes a clinical type, it was with us the one type in which there was a direct ratio between the nature of the disorder and the possibility of adjustment.

Only 2 out of the 6 epileptics were listed as failures, but they were a group extremely prone to limit their contacts with us to a first interview, not only because they were usually getting enough compensation from the government to cover their needs, but also because we had so very little to offer them, that little requiring an effort of will which they were hardly in a condition to make.

It must also be remembered that in listing a man as a failure, I state advisedly that it was to our knowledge. What many of our men who could work and wouldn't did on the outside remained a mystery. Some were undoubtedly panhandlers, "moochers", and "bums". One was found to be a pander who had been plying his trade among the many men in the waiting rooms of the Veterans' Bureau, and there were probably more such. Several well-dressed men obviously had access to underground channels of support. Out of our 500 men, 168 admitted that they were receiving outside support at the time they came to us, this assistance coming variously from charity, their families, or their friends. One exceptionally well-appearing and well-spoken young man, who was persistently unable to do even the simplest work, despite his fairly good physical condition and a minor neuropsychiatric disability, finally told us that his wife, who was a nurse, was earning $200 a month and that her mother was giving them an apartment almost rent free.

The attitude of employers and the public toward our work and the men with whom we dealt may be mentioned briefly. During the year, several hundred employers were interviewed. Quite a bit of publicity was given the work in newspapers, and representatives from most of the men's and women's clubs in the city sat from time to time with our committee and lent us their coöperation.

In our industrial contacts we found our most satisfactory dealings to be with the employment managers, the men who actually had direct contact with each worker in the plant. These, because of practical training and direct experience, gave our experiment more intelligent interest and sympathy than did as a rule the plant owners who, as representatives of the coöperating men's clubs, theoretically lent us their support.

Both the employers and the general public, however, were unsympathetic toward the neuropsychiatric cases. A neurotic condition in adults, as in children, was generally regarded more as evidence of original sin than as an hereditary or developmental defect of the nervous system. Even mention of the fact that a man had a neuropsychiatric disability was often sufficient to make an employer absolutely deaf to further appeals on the man's behalf. "We absolutely can't use any of these shell-shocked fellows", was the general response. One large plant owner, who had told us that he would try to make a place in his plant for some of our men, refused to consider the first man about whom we appealed to him, for this reason. "If he had anything real the matter with him", he said, "I'd try to fit him in. But I can't use these nervous fellows."

This objection to the "nervous fellows" had several substantial grounds. They invariably had a bad effect on their fellow workers. Instead of the normal group acting beneficially upon the neurotic, the neurotic was far more apt to have a detrimental influence upon the group. The other workers, observing his peculiarities, would egg him on for their amusement, a proceeding that generally ended in a fight. Or, if his eccentricities were too marked, they would become frightened and leave. Or they might be sympathetically affected by his demoralized condition and assist him in stirring up trouble in the plant. These reasons were among those most often men-

tioned by the employment managers and there were added to them many others. Even where the manager himself felt equal to coping with the neurotic individual, the section foreman, under whom the man would work directly, was practically never able to do so, having achieved and retained his position not because of a knowledge of abnormal psychology, but because of his ability to get the maximum output of labor from his men.

The complete emphasis of industry on a maximum of output with a minimum of turnover cannot be too often repeated. Both foremen and employment manager are held responsible in this and their own jobs depend on their ability to effect it. Even the welfare work of the plant must tend to increase this efficiency and not, by the admission of an unstable neurotic to whom work is still a medicine, risk lessening it.

This completely concrete element of maximum efficiency was always superimposed upon the less definite, but natural antagonism to the strange and incomprehensible in the neurotic constitution. As all of the managers reiterated, business had to be done, it could only be done if the workers stayed there to do it, and neurotics very rarely did "stick" anywhere. The well-known instability of neurotics was really a greater factor against them than their possible demoralizing effect on their co-workers.

We never found an employer who would promise to take on a man, sick or well, no matter what his recommendations, until he had interviewed him personally. And the result of a personal interview depended as much on the man as on the employer. It depended most of all upon the *man's inner willingness to work.* Until this inner adjustment had taken place, economic adjustment proved to be impossible.

Dr. Bjerre, in the *History and Practice of Psychoanalysis,* states that "every one may chance to go astray; but when he least suspects it, he feels the iron grip of necessity which carries him back where he must go", and indicates that it is the inability to feel this "iron grip of necessity" that stigmatizes the neurotic.

If, in attempting to bring about a man's adjustment, we applied any general method, it was that of what I have termed positively motivated discipline. By this I mean our endeavor

to apply the pressure necessary to each individual to bring him to the point of feeling the "iron grip", of facing reality for himself, by whatever means that individual offered. Where this threshold of reaction to the necessities of reality lay could be discovered only by experiment and was always to be individually determined.

This insistence of ours upon treatment that led to self-reliance was based upon a conviction which, with increasing experience, became the most fundamental part of the work. Real psychotherapy lies, of course, not in doing things for the patient, but in getting him to do them for himself. It is an old and well-established conclusion, but, in the light of my own experiences as a psychiatric social worker, it will bear infinite repetition.

THE PREVENTION OF POOR APPETITE IN CHILDREN

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AMONG the behavior disturbances of childhood, refusal to eat ranks high in order of frequency. It interests the pediatrist as well as the psychiatrist, for whereas it presents a problem in treatment to the latter, in many instances it upsets the best planned treatment of the former. Refusal to eat often makes the prescribing of a dietary régime pure mockery. Unless a method for its prevention or a satisfactory and widely applicable curative procedure is found, much of the benefit of scientific feeding will be withheld from a fairly large proportion of our rising generation.

The chief purpose in submitting this article to a psychiatric publication is to present for consideration the thoughts of a physician on this subject. My feeling is that in meeting this problem satisfactory results can be obtained only through intelligent coöperation, because it is neither a purely psychiatric nor a purely physiological problem. Possibly some of the physiological factors in the production of this widespread condition are not as well known in psychiatric circles as is to be desired. Certainly physicians do not begin to know what they should of mental hygiene. If too much stress is here laid on the importance of physical causes as inciting factors in the condition, and too little on the mental conditioning of the child, it is perhaps because I am more familiar with the former and because such considerations give me a more tangible base from which to build up an hypothesis as to the genesis of anorexia. But whatever my views as to the original cause may be, it is fully recognized that the established case of chronic anorexia in childhood is usually a purely psychological problem. (It will be understood, of course, that

I am here referring only to anorexia for which there is no discoverable physical cause.)

Not only is this condition serious from the standpoint of the child's nutrition, but the oft-repeated battles at meal time have a bad effect on his mental equanimity. They certainly upset the mother's peace of mind. How can a serene atmosphere surround a child who three times daily is urged, threatened, petted, spanked, or hectored into eating his meals? Not infrequently the parents, as a result of these trials, need psychiatric treatment more than do their "won't eat" children. Possibly this is due to the fact that in this problem more than in any other behavior disturbance, the child is likely to have the upper hand in the strife. He can always secure the honors of the day by vomiting.

We have then to deal with a chronic behavior problem, due to physical or mental cause or both, which is detrimental to the physical and mental health of child and parent. This condition, when firmly established, is not as a general rule being successfully treated, and, I believe, cannot be cured except by skillfully applied psychiatric measures.

Confronting this situation, after much illuminating experience with children of this type and their parents, I became convinced that, in my hands, prophylaxis rather than treatment held out the better hope of success. About five years ago, therefore, I began to try to raise a brood of youngsters who would be glad to eat.

At the outset it was assumed that all animals are born with an appetite, and that the problem ultimately resolved itself into doing all the things that would stimulate this appetite and omitting those that would tend to destroy it. From the first it was appreciated that psychic influences would probably play an extremely important rôle in prophylactic treatment, because appetite is largely a psychic function. This paper will report some of the observations made during these five years, and will attempt to give an estimate of the results obtained.

The prophylactic measures used were in general as follows:

1. *Propaganda.*—Mothers and nurses were instructed as to the nature of the condition while their babies were very young, under two or three months of age. They were emphatically

told never to urge their children to eat except under express orders, and were asked to report refusal to eat just as they would report vomiting or loose stools. This resulted in my being able to combat the condition before it was of such long standing as to have become a fixed habit. It gave prophylaxis a chance.

2. *Treatment of the first attack.*—A marked reduction in diet was almost always the first measure prescribed, no matter what was considered to be the cause of the anorexia or what treatment was considered necessary to combat this cause. It is necessary to digress here to emphasize a point that is well known to pediatrists, but that has not, I believe, been stressed sufficiently to the laity. That is the fact that anorexia is usually the first symptom of acute and chronic infections. It precedes all other symptoms of the common cold by at least one or two days. Therefore, when a baby first refused its bottle, the mother was told to reduce the feedings and to look out for an upset of some sort. Looking back, I now consider this the most important feature of prophylactic treatment. Many instances have come to my attention in which chronic anorexia dated from the onset of an ordinary cold. Instead of reducing the diet, the mother became determined in her efforts to feed the baby, and from this unpleasant struggle over the bottle at a time when the child was physically not fit to eat, the child developed an aversion for food on a psychological basis. He first learned to associate unpleasantness with food. If left alone with appetite as a guide, the baby in a few days would have been ravenously hungry, and would have made up for lost time; but forcing him to eat gave rise to a psychological aversion that dulled the returning appetite, and the basis for a prolonged illness was established.

While I do not intend to discuss the treatment of the cause of these first attacks of anorexia, it may be interesting to enumerate a few of them. The common cold, teething, infections—both acute and chronic and especially those of the upper respiratory tract—gastro-intestinal disturbances, car sickness, various food idiosyncrasies, and the like, were common physical causes. Change of attendant and the arrival of a new baby in the household of an hitherto only child are illustrations of psychic causes.

3. *Prevention of weaning difficulties.*—Since it was soon found that many cases had their beginning at the weaning period, prevention of difficulties at this time took on an important aspect. To this end, all babies were given an occasional bottle from birth, often enough so that they remembered the bottle as a friend, not as a stranger. This method practically eliminated weaning difficulties from the standpoint of the child's willingness to take food other than breast milk.

4. *Avoidance of sudden marked changes in the character of food.*—Since it was often difficult to get the babies to make such marked changes as from cereal to vegetable without a struggle, and since at the outset it was decided to avoid all things that would tend to make trouble, all changes were made gradually, vegetable being mixed with cereal, for instance, if the child at first objected. Cod-liver oil and orange juice were given from the first weeks of life so that the babies could accustom themselves to the taste early.

5. *Avoidance of overfeeding.*—All babies were put on the minimum diet that would cause a satisfactory gain in weight in an effort to have them always drain their bottles. Increase in formula was seldom made because the baby seemed hungry as long as he was making a satisfactory gain. This part of the routine involved a great deal of education of the parents, because what was a satisfactory gain to me did not always appear so to them. Many people look upon rapid gain in weight as the most important index of a baby's welfare. It is difficult to make them understand why a baby should be held down to a reasonable gain when a neighbor's child is apparently well and gaining much faster. The neighborhood-baby race is a great obstacle to conservative pediatrics. The public should be educated to the fact that a small baby may be physically superior to a much larger competitor.

6. *The prescribing of no definite amounts of food after one year.*—Mothers were told to let the child's appetite be the guide as to how much he should eat, and were given only general statements as to the amounts of food to be given. No caloric diets were prescribed, as mothers were told to give their children food, not calories. This tended to remove many difficulties during the second year.

7. *Telling mothers to leave their children alone at meal times.*—The children were also to be taught to feed themselves as early as possible.

8. *Allowing the child's appetite play in choice of food.*—In the main, the child was humored as to choice of food. This is not to be interpreted as meaning that he was allowed to eat anything he pleased. But where there was a choice between two foods, the one that the child liked best was most often used. It was not considered advisable to make the child eat everything "so that later on he would like everything", because, in the writer's experience, this really means that the child is more likely not to enjoy eating anything, the repetition of struggles resulting from insisting on especially disliked food tending to produce a psychological distaste for all food.

9. *Avoidance of pitched battles over meals.*—Parents were instructed that nothing could be worse for the child's nutrition than repeated emotional strife at meal time. This point has always been insisted upon.

10. *Requesting mothers to read standard works on child psychology before behavior disturbances had had a chance to develop far.*—At or before one year of age H. C. Cameron's *The Nervous Child* was usually suggested as a good introduction to the subject.

This report of results is based on the statistics gleaned from a questionnaire sent out to the mothers of 215 consecutive children over eighteen months of age. In selecting these cases, I simply went through the files and took out the first 215 histories of children whom I had seen from early infancy until the present time. No exceptions were made on account of acute or chronic disease of any sort. It was hoped that this might show whether or not it paid in appetites to take the trouble of going through the previously outlined routine. The text of the questionnaire is as follows:

In connection with some investigations I am making about the appetite of children, I am asking you to fill out the following questionnaire:

1. Does your child usually eat

a. hungrily?
b. willingly?
c. reluctantly?
d. with great aversion for food?

2. What is the approximate weight with clothes on?

3. What is the age in years and months?

"Your frank and prompt reply will greatly facilitate this work and be appreciated very much. Thanking you, I am," etc.

Of the 215 letters sent out, 199 were returned. The results were tabulated. It has seemed best to present them in three tables, one showing a summary of the entire group, one a detail of the children who were underweight, and the other a detail of the group who ate reluctantly. In the subsequent discussion it will be taken for granted that the children who ate hungrily or willingly present no appetite problem. It was gratifying that there were none said to eat with aversion to food and that none habitually vomited their meals. It is quite evident that a child one or two pounds underweight can in no way be called abnormal. However, it was thought best in a statistical study like this to include them in the table of underweight children. It should be clearly borne in mind that there is a great difference between the underweight and the malnourished child.

As to the reliability of the information given, I leave it to the reader to judge. Most of the mothers had discussed the problem one or more times with me, and were more or less familiar with it. Undoubtedly some would paint a rosy picture, but I am inclined to think that the average reply was fairly conservative. Unfortunately it was impossible for me to study a control group. Statistics as to the prevalence of anorexia are few in spite of the mass of evidence as to its widespread existence. Studies made by Maclay[1] and by Mosely[2] under the auspices of the Department of Home Economics at Chicago University, however, offer some basis for comparison. The children examined in these researches were of pre-school age and were from approximately the same type of homes as those reported on here. Miss Mosely found among 100 children only 19 who were good feeders, whereas in my group there were about 85 per cent.

Consideration of the value of these statistics must also take into account the possibility that many people, discouraged by

[1] *A Study of the Prevalence and Lack of Appetite in One Hundred Pre-school Children,* by Eleanor Maclay. Chicago, 1924.

[2] *Reaction to Food of Children of Pre-school Age,* by Marion R. Mosely. Chicago, 1925.

the failure of the prescribed routine, may have sought other advice. In that event this report would comprise most of the successes and leave out many of the failures. There is no way of telling whether this has happened, but I am not aware that any such instance has occurred.

Furthermore, there is no way of telling how these children were actually treated. All that can be stated is that the parents were instructed as outlined above. To what extent instructions were obeyed, we cannot tell. However, I can conceive of benefit to the child ensuing from such direction of parents even if they did not carry out orders. Lack of worry in the parents' attitude might go a long way toward preventing anorexia of this type. Judgment of results, then, must be drawn from consideration of what was known to have been told the parents rather than on what may be assumed to have been done for the child. If it can be demonstrated by statistical studies similar to those referred to above that children whose parents were not so instructed have poorer appetites than those reported here, then it will be justifiable to claim prophylactic merit for the effort.

TABLE I. SUMMARY OF ENTIRE GROUP BY AGE PERIODS

Age period	*Number of cases*	*Number eating hungrily*	*Number eating willingly*	*Number eating reluctantly*	*Number underweight*	*Average pounds overweight*
18 months–2 years.....	43	19	21	3	1	3.8
2–3 years	56	18	29	9	2	3.8
3–4 years	43	16	22	5	3	3.7
4–5 years	33	6	18	9	8	3.0
5–6 years	24	12	8	4	7	3.7
Total	199	71	98	30	21	
Percentage	100.0	35.7	49.2	15.1	10.6	

This table summarizes all of the replies according to the various age periods. I can see no very striking relationship between age and appetite except that there were a larger proportion of reluctant eaters after the two-year-old period. The entire group, including in the computation those underweight, averaged 3.6 pounds overweight for age. Perhaps it would have been more satisfactory to have included in the questionnaire a query as to height, but I feared it would delay

and reduce the number of replies to add many details, and I felt that with so large a number of cases the height could be assumed to be about normal. If I had anticipated that these children would average so much overweight, the height question would certainly have been added. As it was, investigations as to the height of some of the underweight children were made after the return of the questionnaires. Table I demonstrates conclusively that, from the standpoint of the nutrition of the child, it is safe for the pediatrist to advise strongly against forced feeding, provided he applies such prophylactic measures as are outlined above.

TABLE II. SUMMARY OF DATA ON UNDERWEIGHT CHILDREN

Case number	*Pounds underweight*	*Appetite**	*Comment*
19	1	R	Congenital heart disease
51	1	H	Premature baby
63	3	R	
120	3	R	Recurrent vomiting
125	2	W	
130	3	H	Premature baby
146	2	W	
148	2	H	
152	3	R	Cœliac disease
158	3	W	
163	2	W	Chronic pyelitis
167	5	R	Chronic pyelitis
168	2	W	Chronic pyelitis
173	1	W	
180	6	W	Chronic tonsillitis with hypertrophy
187	3	R	Chronic tonsillitis with hypertrophy
191	1	R	
192	1	R	
195	6	R	Chronic tonsillitis with hypertrophy
197	4	H	
198	4	W	

* H—Eats hungrily
W—Eats willingly
R—Eats reluctantly.

Table II summarizes the statistics on the underweight children. It is interesting to note that of the 21 children, 13 were less than 10 per cent underweight, and that in the case of 11 of the 21, there was an adequate physical cause for the nutritional condition. Closer study showed that of the children who were free from physical disease, only 3 were more than one pound underweight for their height (Cases 125, 146, and

158), and that these children all ate willingly. It is not considered that one pound underweight is abnormal; therefore, this table seems to indicate that in the entire group of 199 unselected children, there were none who were underweight because of poor appetite except those who were suffering from chronic disease.

TABLE III. SUMMARY OF DATA ON THE RELUCTANT FEEDERS

Case number	*Age*	*Pounds underweight*	*Pounds overweight*	*Comment*
19	1	1	....	Congenital heart disease
24	1	....	1	
42	1	....	1	
49	2	....	6	
52	2	....	3	
56	2	....	2	
57	2	....	2	
63	2	3	....	
70	2	....	3	
86	2	....	2	
90	2	....	5	
91	2	....	5	
106	3	....	4	
115	3	0	0	
120	3	3	....	Recurrent vomiting
138	3	0	0	
139	3	0	0	Chronic pyelitis
142	4	....	9	
144	4	....	2	
151	4	....	2	
152	4	3	....	Cœliac disease
154	4	0	0	
156	4	....	5	
164	4	0	0	Congenital spastic paralysis
167	4	5	....	Pyelitis
170	4	....	3	Chronic tonsillitis with hypertrophy
187	5	....	3	Chronic tonsillitis with hypertrophy
191	5	1	....	
192	6	1	....	
195	6	6	....	Chronic tonsillitis with hypertrophy

Table III summarizes the data on reluctant feeders, the failures in this attempt to produce hungry children. Of the 30 children, 9 had disease processes that may reasonably be blamed for the anorexia. Of the remaining 21, only 3 were underweight for age (Cases 63, 191, and 192). Two of these were only one pound underweight, and the other child was

overweight for her height and was really quite plump. It is evident that even among these poor eaters, the difficulty had not reached proportions severe enough to produce malnutrition in any case.

As would be expected, investigation as to the cause of these failures was illuminating. In the first place, I found to my surprise that there were several mothers to whom I had never spoken of the problem. They had gone on forcing down food because they thought it was the right thing to do. It must be concluded that in spite of good intentions, the work was imperfectly done. Lack of time, forgetfulness, and lack of opportunity to see the children at the right time were to blame. On the other hand, there were parents who did not do as directed. They failed to do so for various reasons. Some undoubtedly tried to leave their children alone at meals, but just couldn't do it. Many parents are so constituted that they have to see to it that what their children do is done *because* they supervise it. They need a lot of education. Evidently in some instances here I did not "sell" the ideas strongly enough to get the desired results. Popularization of this subject would help the doctor a great deal among these people. The bogey of malnutrition has been so strongly urged, and the advantages of proper feeding so admirably demonstrated, that many people lack perspective and reason when it comes to a consideration of *how* their children eat. In this community—as in many others, I suppose—when I began this work, practically all the "enlightened" were dominated by the idea that children must be made to eat the definite, set formulas prescribed by their physician, nurse, government-health bulletin, or whatnot agent. Instilling the ideas here presented was, therefore, particularly difficult. It was hard to make people understand that I was doing this because I wanted my formulas to be eaten, not because I did not care what the children ate. This is stressed because it is evidently necessary to call in the aid of propaganda if complete success is to be obtained.

It seems proper to insert a word in regard to parent baiting. It has become more or less popular to blame parents for all troubles of this kind, even to poke fun at them. It seems to me particularly illogical and futile, not to say unkind, for

doctors, nurses, or child-welfare workers to do this, at least until such time as they have thoroughly popularized proper instruction along these lines to parents. We must first reach unanimity of purpose ourselves, then broadcast it in no uncertain terms, before we can expect these perplexed, striving, and devoted parents to act properly. This applies to other psychological problems as well as to that of eating. It is, therefore, encouraging that physicians are interesting themselves in the strictly non-medical aspects of child welfare, and that psychiatric workers are placing increasing stress upon propaganda efforts.

CONCLUSIONS

1. Chronic anorexia may be considered as developing in two steps: First, a readily understandable physical or mental cause results in lack of appetite. Then, a forcing of food at this time, when proper regard for the situation would counsel a withholding of food, fixes upon the patient a psychological aversion for food from which he may recover with great difficulty.

2. A method of preventing the development of this condition in young children is outlined.

3. The results of this treatment as shown by the statistics of 199 consecutive cases demonstrated the following:

   a. That it was not harmful to the nutrition of children to advise the parents against urging their children to eat—provided the prophylactic measures prescribed were taken—because this group of cases averaged 3.6 pounds overweight.

   b. That there were no children in this group who were malnourished except those who were suffering from chronic disease of some sort.

4. It is necessary, in order to combat this condition successfully, that propaganda against the forced feeding of children be pushed.

PROGRAM FOR MEETING PSYCHIATRIC NEEDS IN THE STATE

AIMS AND PROBLEMS OF THE ILLINOIS PLAN *

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SINCE one can never really make an entirely new start even with so relatively new a subject as the psychiatric problems of a state, it will be necessary to outline briefly the historical developments of the work in Illinois in order to explain the present situation and the reason for the plans we are carrying out.

Briefly, the first application of psychiatry and psychology to behavior problems in this country was at the Juvenile Psychopathic Institute, founded in Chicago in March, 1909. The idea was the conception of Mrs. William F. Dummer, and the tremendous progress that has been made, not only in this community, but in the development of other clinics throughout the country, bears testimony to Mrs. Dummer's wisdom. Dr. William Healy was appointed the first director, and for five years the institute functioned under private support from Mrs. Dummer. This five-year period was a demonstration, the avowed object of which was to convince the officials and the general public of Cook County of the value of the work, with the idea that when this was accomplished, the support of the institute would be officially undertaken by the county.

This method of demonstration was not new, and similar demonstrations have been carried out since. The work of the child-guidance clinics of the Commonwealth Fund and The National Committee for Mental Hygiene have been organized on this same basis. This method of creative work is perhaps the outcome of a former, less constructive method—namely, the social survey. The survey method is one that has proved very useful in the past and is still of value to-day under cer-

* Read at the National Conference of Social Work, Cleveland, Ohio, June 1, 1926.

tain conditions. For reasons that will appear later, however, I hazard the statement that unless a survey or a demonstration such as that of the first five years of the Juvenile Psychopathic Institute is applied under unusually favorable conditions, permanent success is very doubtful. The survey as employed in public service is usually conducted as the result of dissatisfaction with existing conditions on the part of a group in the community, or as the result of a scandal. The survey usually ends in a report in which constructive suggestions are made. While some surveys have been eminently successful in establishing permanent improvements, too frequently this has not been the case. By the time the report is rendered, the original excitement has died down and the report is filed and nothing done. Furthermore, survey officials are usually handicapped by the brevity of their acquaintance with the field that is being studied and by their ignorance of details that, in themselves unimportant, may nevertheless be decisive as to the practicability of the final recommendation made. Many a scheme that appears satisfactory and logical on paper has failed of adoption—or of practical effectiveness, if adopted—because of the neglect of some of these details. Demonstrations, on the other hand, have the advantage of actually carrying out work under the conditions that any permanent organization will have to meet. There is, therefore, the possibility of actually doing the work intended and thereby silencing any objection that the plan is visionary.

The Juvenile Psychopathic Institute during its first five years overwhelmingly demonstrated not only the practicability of the project, but also its great value. Not only Chicago and Cook County, but the entire country was inspired by what Dr. Healy and his associates accomplished. As a result, at the end of the demonstration period, the commissioners of Cook County accepted the institute as an official obligation of the county. Early in the winter of 1917, however, Dr. Healy was offered his present position as director of the Judge Baker Foundation in Boston. He was granted a three-months leave of absence, in order to be able to return in case he should find that the Boston position did not offer what he wished. At Dr. Healy's suggestion, the judge of the

juvenile court requested me to take Dr. Healy's place, and I, therefore, assumed the directorship of the institute, with the understanding, of course, that Dr. Healy might return at any time he cared to. I have repeatedly told him, and am glad to have this opportunity to reiterate, that although his leave of absence expired long ago, my offer of holding the place pending his return is still open.

In view of Dr. Healy's very remarkable record at the institute, it was natural that, on his departure, the public should lose some of its interest. This loss of interest was soon made manifest on the part of the commissioners of the county, and it was not long before word came to Judge Arnold, of the juvenile court, that the commissioners of the county were pressed for funds, that economy was the watchword, and that they would have to retrench. It was natural that in looking around for some place to save money they should select the institute as an agency without which the county could continue to exist. Judge Arnold, therefore, informed me that at the termination of the fiscal year, there would be no funds for continuing the work.

In the meantime Governor Lowden had been inaugurated, and had completed the draft of the civil administrative code which organized the administration of the state. This included, among other departments, a department of public welfare, with a director who had charge of all the charitable, penal, and correctional institutions of the state. In the department of public welfare there was a division of criminology, to be in charge of a criminologist—a specialist who was to apply scientific methods of research to the problems of criminal behavior. When Mr. Charles H. Thorne, director of the department of public welfare at that time, approached me with the request that I take this position of criminologist, I agreed, and it was decided that the work of the Juvenile Psychopathic Institute should be continued as the preventive work of the division of criminology, under state support. The work has been thus continued from 1919 to the present.

Summing up the work to this time, then, we see that even with so successful a demonstration as Dr. Healy's five-year period, after two and a half years under public auspices the work broke down and could no longer be supported by the

county. It would seem, moreover, that although a state is a better protection than a smaller organization such as a county or a city, nevertheless even here really thorough scientific work cannot be carried on with complete security. There are some very important, if not fundamental considerations at the base of this. In the first place, all state enterprises depend on appropriations from the legislature. While in practice there is frequently no great risk of the state's abandoning any worth-while undertaking once it has successfully established itself, the dependence on appropriations has certain serious disadvantages. The first of these is the uncertainty as to the possibility of expansion commensurate with the development of public opinion and demands. In the second place, it is difficult to secure for the public service the kinds of personnel that are required for the work. Security of office is essential for obtaining good personnel. The civil service is no help here, but rather a disadvantage at times, since in the first place civil service is not an absolute guarantee, and furthermore, as operative in this country, it tends to standardize, so that it is not possible to create individual positions to fit particular persons. Of course this difficulty is not encountered in the case of positions for which there is an adequate supply of personnel. But when it comes to the highly specialized field of behavior problems, where psychiatrists, psychologists, and social workers of individual ability are necessary, civil service is in many states not elastic enough.

There is a final point in connection with this method which has been pressed upon our attention. It is the purpose of surveys and demonstrations to arouse a sense of obligation on the part of public officials. However much it may be minimized, there is always a flavor of antagonism in such a procedure. Social workers are generally regarded as "reformers" by public officials. New undertakings are started by attacking public administrators and threatening to reveal their incompetency. Of course there are many instances in which public officials have taken the lead and have shown a conscientious attitude toward obligations. Those states are fortunate in which this has been the case, but in no state has such a condition been continuous enough really to accomplish

what should be accomplished, and in some states the progressive and conscientious administrations have been short-lived. Ultimately, of course, such conditions must and will be changed, and it is to be hoped that some day we shall be able to separate public service from the peculiarly political functions, so that we shall have a civil service here comparable to the British civil service, which offers careers for individuals competent to do the work.

But whatever may come in the future, we are faced with the present situation, and under our democratic form of government, in which service is a part of policy and therefore subject to political control—even if to no greater extent than that appropriations are dependent upon opinion in the legislature—we must acknowledge the facts. I say this in no critical sense, but with the feeling that even under the present system of conducting public business, we can establish work of the kind in which we are interested on a firm basis. The history of such states as Pennsylvania, New Jersey, Ohio, Michigan, Indiana, Iowa, and Illinois is ample evidence that this is true. It is perhaps just as well that the situation is as it is, because it requires on the part of every one an attitude of tolerance toward others. I personally doubt very much whether, if the National Conference of Social Work were given the authority to conduct all the welfare of all the states represented in it, we should be successful. We should probably be less so than we have been with the help of the legislators and public officials trained in politics and the administration of public affairs.

Since the founding of the Juvenile Psychopathic Institute in Illinois seventeen years ago, the idea has developed and spread so that the demand for this type of service has become far greater than can be met by the supply of trained workers. Until recently the plan has been for every institution dealing with behavior problems, every school or school department, every philanthropic organization, to equip itself with a mental-hygiene clinic. The recommendations of The National Committee for Mental Hygiene for this purpose have been very specific and fit in well with the procedure in Illinois and elsewhere. According to this, a minimum unit staff consists of one director (a psychiatrist), one psychologist, one chief

psychiatric social worker, two assistant psychiatric social workers, one secretary, and two stenographers. As the demand increases, however, and the problem becomes one of meeting the needs of an entire state, as in the state of Illinois, the amount of personnel necessary is greatly increased and is difficult to find. The National Committee for Mental Hygiene, the Commonwealth Fund, and other organizations have the same experience. There are not enough clinical psychologists, psychiatric social workers, or psychiatrists experienced in the behavior field to meet the needs of the clinics that are even now established. Accordingly, in Illinois we are increasing our training facilities so as to provide more trained personnel. The Commonwealth Fund is similarly planning a program for training personnel. It is apparent, however, on careful consideration, that no matter how much the training facilities may be increased, and no matter how many more workers become available, there are certain inherent facts that will prevent our meeting the situation on this basis. We believe that the work done in these clinics has something to offer to every individual in the community, old and young. At the present time—and probably the same situation will hold for some time to come—to do thorough work in this field requires a great deal of time in each individual case. Therefore, it is clear that it is an impossibility to secure enough qualified personnel to meet the needs of the entire population on the basis of individual service by a minimum staff such as that set up by The National Committee for Mental Hygiene. It is obvious that some division of labor is required, and this must be recognized in planning for any community. Workers of various degrees of competence and responsibility are needed. Large numbers of lower grades of workers can be used, and because the requirements are not too high, these can be secured in sufficient numbers to deal with the problem. They must have a definite understanding of what their function is and beyond what point they cannot go. When they reach that point, there must be more advanced and highly trained workers to whom they can refer their cases for more information or for transfer. Finally, the center of the entire system must be a consulting staff of highly qualified experts who can determine policies. This central staff should

constitute the headquarters and should combine all of the three functions of such an organization—service, training, and research. These three functions are intimately bound up with one another. Thus the service function offers opportunities for practical training and for research, and the research in turn adds to the effectiveness of the service performed.

Based on these considerations, the plan for the state of Illinois, as at present outlined, includes two main divisions of service. The first consists of the institution service, which concerns itself with the study and treatment of individual cases in the state penal and correctional institutions. According to the organization of the department of public welfare, there are also certain institutions which utilize the services of the mental-health organization under the division of criminology without being officially assigned to that division. These are the two institutions for the feebleminded and the schools for the deaf and the blind, as well as the soldiers' orphans' home. The other division of the work is designed to be preventive and extramural. This part of the work consists of the service given at the headquarters and its out-patient clinic, the branch at the Juvenile Detention Home of Cook County, the pre-school and nursery-school work at Hull House, and the work at the LaSalle-Peru Township High School and the Glenwood Manual Training School. In addition to this there are traveling clinics which visit periodically the various cities of the state.

This plan calls for a permanent unit at each of the institutions, two traveling clinics on permanent duty, two units at headquarters, and one unit at the juvenile court. At present this plan is by no means complete in its operation because of the scarcity of personnel—particularly because of the difficulty of obtaining clinical psychologists and psychiatrists not only competent to do the work, but willing to go out into the field and be stationed at the penal and correctional institutions—but it is gradually being put into effect. We have now an almost complete unit at the penitentiary at Joliet, where we have a psychiatrist, a part-time psychologist, and a clerk, and are about to add a psychiatric social worker. The reformatory for boys at Pontiac and the Southern Illinois

Penitentiary at Menard are covered by visiting clinics at monthly intervals. We are about to put in a permanent staff at the reformatory. A clerk is assigned to each institution, and at present there is a psychologist at the training school for boys at St. Charles and at the school for girls at Geneva. The headquarters—that is, the Institute for Juvenile Research itself—have recently been moved to a modern fireproof structure which affords better facilities for the development of the work. This, however, is still a temporary building for us, and we expect in the near future to have a permanent building designed for our needs. At the headquarters there is a chief psychiatrist, a chief psychologist, and a chief psychiatric social worker, each of whom is responsible for the entire service of his division of the work.

In addition to this service staff, there will be attached to headquarters a body of research workers of various grades, from graduate students to recognized authorities in the lines of work undertaken. Research in the past has been conducted under difficulties because of inadequate funds and space and because of the immense pressure of the service work. Recently, however, a committee of citizens of Chicago, realizing the importance of the work that is done at the Institute for Juvenile Research and the opportunities for research that the clinical material offers, undertook to raise a sum of money to be used for independent research in problems of human behavior. This fund, which is called the Behavior Research Fund, is now complete, and the organization of the work is being planned, to begin officially October 1, 1926. The fund amounts to $55,000 a year and is guaranteed for five years, and there is every indication that it will be made permanent before the end of the five-year period. Thus it will be possible to attract to the work here scientists who would not have been willing to consider the risk involved in accepting a position under state appropriation, with the potential danger of the support being withdrawn at any time. The security and continuity guaranteed by this arrangement are comparable to those of a university. Moreover, the opportunities for conducting research in human-behavior problems is far better at the Institute for Juvenile Research than at any university at present, because of the close knitting of public service with

research, the tremendous facilities and clinical material of the state being made accessible to the scientist with the least possible effort involved. Nor will the research workers have to interrupt their work to fulfill service obligations or demands. The service staff will attend to all of that and the scientific workers in research will be protected against any interference.

With this arrangement, moreover, it is obvious that there is an ideal opportunity for training students and workers in the various specialties represented. In order to facilitate the use of these opportunities for graduate students, the Institute for Juvenile Research will effect an affiliation with various universities, so that the work done by students at the institute under the supervision of the senior staff will be counted for credit at their respective universities.

PSYCHOANALYSIS AS A CULTURAL FACTOR *

OTTO RANK
Vienna

I TRIED in a former paper [1] to outline the purely practical side of psychoanalysis, and to show the possibilities in its application to our daily life and social organization. I did this because in my opinion it would be regrettable if psychoanalysis were considered either as merely a therapeutic method or as pure theory. The truth lies between these two extremes—namely, in its applicability to vigorous life—and that in my view is its chief value. Freud's genius consists in the fact that although he started with the pathological, he did not stop there, but made possible a keener perception and a deeper understanding of what is natural and human everywhere. His concept has a closer relation to the content of folk beliefs and popular traditions than to dry doctrine, and so it has never lost its contact with reality.

I do not know whether I shall have your general assent to the assumption that this may be one of the reasons why scientists have been from the very beginning so opposed to psychoanalysis. I believe that they do not want to recognize psychoanalysis as of their kind. In my actual hearing it has often been spoken of as an art and not as a science. The scientists are, as it were, embarrassed to show themselves publicly in its company, and then, too, they suspect a little its widespread popularity. And so, in spite of zealous endeavors and certain concessions on the part of psychoanalysts, it is not surprising that psychoanalysis has not succeeded in influencing the natural and mental sciences to an extent commensurate with its scientific importance. All attempts to apply psychoanalysis to the solution of unsolved

* Read at the New School for Social Research, New York, May 26, 1924.

[1] *Psychoanalysis as General Psychology.* MENTAL HYGIENE, Vol. 10, pp. 12–26, January, 1926.

problems in the various spheres of science have until recently, with few exceptions, been originated by the psychoanalysts themselves. A criticism of their often very surprising achievements in throwing new light on various problems was certainly all the easier for the experts because the psychoanalysts naturally lacked sufficient knowledge in the particular branch of science involved to satisfy all its claims in their work. The scientists themselves, hitherto critically holding aloof, have resisted the application of psychoanalysis in their various fields. On the other hand, the cultured public, in so far as the problems dealt with were of general interest, accepted the analytic point of view much earlier and more easily and has to a certain extent assimilated psychoanalytic thought because of its general human appeal.

Thus, in going beyond its original field of work—the investigation and healing of neuroses—into normal fields where its knowledge could be practically applied, psychoanalysis has influenced the subject matter of the various sciences earlier and more effectively than it has the sciences themselves. The sciences will probably only slowly and gradually adapt themselves to the changed state of affairs. I do not want you to misunderstand me and to get the impression that I am reproaching the sciences. The historical character seems the essence of science in general, which only tells us how things happened. But the sciences seem to show also a disposition that Freud has described as characteristic of the neuroses—they suffer from reminiscences. In other words, they show a tendency to remain fixed in some early stage of their development. It may be that this results from the psychology of their representatives, the scientists. Be that as it may, psychoanalysis has encountered resistance in the representatives of particular branches of science.

In medicine, to start with the narrower psychoanalytic field, the neurologists and psychiatrists, under the spell of a materialistic conception, rejected psychoanalysis as unscientific long after it had to its credit such therapeutic successes as had never before been attained in these two branches of medicine. Later, when this fact could no longer be ignored, the convenient formula was evolved: "Everything true in

psychoanalysis is old, and everything new is false or is only an exaggeration of well-known facts." But this, as indeed you know, is the usual reception accorded to the inconvenient results of a new investigation. It seems to be regrettably true that it is left to the inclination of each individual to accept what he can understand and to falsify what he does not understand. Certainly to-day the literature of psychiatry is permeated by the psychoanalytic point of view. But in the meantime the entire medical profession also has begun to recognize psychoanalysis and to take from it whatever is useful and valuable. This seems to have resulted in a tendency toward a separation of the clinical unity of neuroses into smaller groups of partial diseases, which can be treated and cured symptomatically by their respective specialists. Certainly the specialists, who hitherto have lacked any kind of psychological medical training, must for this purpose be trained psychoanalytically as they are trained in all other medical branches of knowledge. In the meantime, however, a process of assimilation of psychoanalytic results has begun quite spontaneously in various special branches of medicine. This has led to surprising results, which nevertheless remain isolated from the main body of medical knowledge. We cannot at all foresee what revolutions in the field of medicine will come about when the medical student has to go through a regular course of training in psychoanalysis as he has to-day to go through a training in, for instance, anatomy and physiology.

The analytic study of hysterical physical symptoms was the starting point for the discovery of the surprising possibilities that lie in the application of psychoanalysis in general medical practice. These symptoms are to be distinguished from those of organic diseases only by a subtle differential diagnosis. From the analysis of such symptoms, which lie in the border land between the physical and the psychical, psychoanalysis has discovered what a large part is played by the psychical in almost all organic sufferings. According to the case, this psychical factor definitely influences the intensity, the permanency, the outbreak, the arrest, indeed often enough the disappearance of the bodily suffering. A certain degree of psychoanalytic knowledge, therefore, is necessary to all med-

ical practitioners, primarily as an aid in diagnosis and prognosis, but also for therapeutic purposes. Internal medicine especially has need of this knowledge, since the uncertainty of its diagnostic method is often made use of, partly unconsciously and partly consciously, by a certain type of patient to embitter his own or his family's life by illness. Here the doctor should be able to use a psychoanalytically trained insight, and to treat the patient accordingly. But he should do this without taking from the patient the psychical gain of illness by an untimely communication of its psychical motives, and so driving him away from psychical enlightenment to further medical treatment, which is what he desires. Rather, the doctor must set this participation of the unconscious discovered by psychoanalysis into its proper place in the big equation whose factors, in their relation of strength and value to one another, often enough decide for life and death. I am not speaking here of those extreme cases of men suffering from severe psychical conflicts in whom we have discovered a will to disease or a will to die, which is able to diminish their power of resisting germs or to aggravate a hitherto harmless suffering into a severe one. We have had opportunity to observe analytically also cases in which death was a welcome escape from apparently unsolvable psychical conflicts, an honorable form of suicide, so to speak, permitted by the patient's own conscience and the judgment of the world. Certain physical sufferings—frequently those of a chronic nature—have for the patient the same unconscious importance, or at least the same secondary gain of illness, as the pseudo-organic symptoms have for the hysteric.

But even the surgeon, especially the gynecologist, should not always yield too easily to the wishes of neurotic patients who desire an operation. We know from psychoanalysis that often an operation has for the unconscious a quite definite libidinal significance, which need not be of a purely masochistic nature, but is regularly connected with infantile traumata, especially castration and birth. In those cases in which an operation is inevitable, the psychologically trained surgeon must prevent the psychical after-effects of the operation. These sometimes cause the patient new sufferings which can bother him more than his original disease. This is especially true of opera-

tions on children, who are far more susceptible to psychic shocks than are adults. I would like to mention as an example the tonsil operation, at present so fashionable. It has indeed certain hygienic advantages, but when you realize that this operation, even though performed under an anæsthetic, means for the majority of children a psychic shock from which they may suffer all through their lives, then in any case you will have to compare, far more carefully than has been done, the physical advantages with the psychical disadvantages of this operation before deciding in its favor. However, American surgeons, as is well known, already consider as much as possible the elimination of the psychic trauma.

But if the application of psychoanalysis in general medical science belongs to the future, even to-day psychoanalysis at least gives us the key to an understanding of the psychical processes in the origin and progress of organic diseases. And I am sure extensive practical results will be gained from this understanding. But here also—and this point I want to emphasize—psychoanalysis already goes beyond the purely medical field in that it has a distinct contribution to make to general social and psychical hygiene, whose aims are not so much therapeutic as prophylactic.

In the beginning, from the point of view of medical science, psychoanalysis was considered to be not sufficiently materialistic; for the mental sciences, it was not sufficiently spiritualistic. Writers and poets were really the first who took up psychoanalysis and found inspiration in it. To them is due a share of the credit for making it known to a wider public. The interest of this literary circle in psychoanalysis is easily understood. The poets have always represented, as it were, the upper ten, in a psychical sense, of the population, which sees itself mirrored and reflected in their works. And when the first fully related case history was published by Freud under the modest title, "*Bruchstück einer Hysterieanalyse*"—that is, *Fragment of an Analysis of Hysteria*—one said of it quite rightly: "It reads like a thrilling novel." It describes the hysterical illness of a young girl with a tender solicitude for the most intimate feelings of her psychical life. Poets of all times, but especially modern poets, have striven to do this, but without success. So the poets, working always from the

unconscious and creating from it, soon recognized in psychoanalysis an ally, if not a competitor, and tried to get from it as much as was compatible with their artistic purposes. But the possibilities in this direction soon proved to be limited. The unconscious material discovered by psychoanalysis was no new factor for artistic representation and was only slightly suitable for artistic creation. The hope of the poets that analysis would open up to them greater possibilities and capacities for artistic production has remained unfulfilled. Nevertheless, psychoanalysis has left its imprint on contemporary literature. And here again I want to emphasize the fact that it was not until some time later that the science in question—that is, the history of literature or art—recognized the fact that the poetic creations of the past were based on unconscious conflicts. Yet psychoanalysis can find corroboration for many of its theories—as, for example, that of the Œdipus motive—in the poets of the past. And contemporary poets, by their acceptance and use of psychoanalytic material, have spontaneously confirmed the fact that poetic creation in general is based on unconscious motives. Some twenty years ago, in a small study entitled *"Der Künstler"* (*The Artist*),[1] I contrasted the analytic process by which the unconscious is brought into consciousness with the process by which the artist creates from the unconscious, and tried to show that they are irreconcilable. I do not know how far you will agree with me that developments since this prophecy have proved its truth. I at least—and others with me—have found that the standard of artists who have been influenced by psychoanalysis has not been, as a general rule, raised. We have found, rather, that the initial enrichment of artistic problems and forms due to the psychoanalytic movement has lately suffered a perceptible depreciation with the progressive conscious revelation of the unconscious.

In another yet more important social and cultural sphere—that of religion—there has also developed, as so often happens in life, from an original affinity a later opposition. Breuer's katharsis, as the name implies, is akin to Aristotle's doctrine

[1] *Der Künstler. Ansätze zu Einer Sexualpsychologie* (*Imago-Bücher I.*) By Otto Rank. Wien: Internationaler Psychoanalytischer Verlag.

of purification of the emotions in the Greek tragedy. Aristotle recognized a therapeutic factor in the freeing of repressed affects through a motive of whose make-believe and unreality the audience is ever conscious. But a similar kathartic task is also accomplished by all religious ceremonials, which Freud many years ago showed to be markedly similar to certain ceremonials practiced by compulsion neurotics. Moreover the original nucleus of the religious ceremonial, the cult of the sacrifice, would be intelligible, in its analytic importance and kathartic effect, not only from the compulsory sacrificial actions of certain neurotics, but also from the masochistic tendency to *self-sacrifice* that we find at the bottom of any neurotic suffering. Again, in its technique, in its rule of free, uninhibited speech, analysis resembles one of the chief rites of the Christian church—namely, confession, with which it has often been compared. The essential difference, however, is this. Confession is only a temporary unburdening of the consciousness of guilt, as prayer is the expression of a momentary wish-fulfillment. Analysis, on the other hand, attempts to remove the need for unattainable wishes, and the seeking for guilt and punishment, by freeing infantile fixations. This naturally enough soon brought upon it the disapprobation of the faithful, who feared that analysis would mean an undermining of religious beliefs, on which indeed a part of the state's authority also rests. This is explained by the fact that both the church and the state are based upon the parental relation—that is, on the human child's need for protection and help.

In judging these subtle questions, one ought not to forget that psychoanalysis itself must obviously be considered also as a phenomenon of our time and civilization. And from this higher standpoint, it represents man's attempt to replace traditional beliefs and customs necessary for the maintenance of society by more appropriate and efficient conventions. Even before the days of psychoanalysis, the psychology of religion endeavored, although with inadequate means, to understand psychologically the phenomena of the religious life; hence, from the standpoint of religious creation, it must be regarded as an attempt at disintegration. It is the privilege of psychoanalysis, however, not only to make possible a deeper under-

standing of religious phenomena, but at the same time to offer a substitute where religion is no longer sufficient for the mastery of individual conflicts. Freud has even said that human beings of the type that now becomes ill with a neurosis and attempts to withdraw from reality in the earlier centuries withdrew to the cloister, where a quite definite kind of isolated existence, devoted to God, disguised their neuroses and made them harmless for society.

And what holds good for religion holds good also for ethics, which is intimately connected with and partly represents religion. Naturally I am not speaking here of the ethical standard whose practical achievement involves legislation and the administration of justice, whose theoretical foundation in the past was largely the work of speculative philosophers lacking in psychological insight. What I mean is individual, everyday conduct. Just here the opponents of psychoanalysis, and the laity who are not yet sufficiently versed in it, fear a harmful influence from psychoanalytic enlightenment. Unfortunately the impression is still widespread that psychoanalysis teaches or furthers freely giving rein to all one's previously suppressed impulses, without consideration for the well-being of one's neighbors or of society. What psychoanalysis really strives for is a better, in the sense of a conscious, mastery of the impulses that through repression produce devastating effects. This holds good especially for sexual ethics, whose undermining by analysis the authorities fear. But as a matter of fact psychoanalysis is in a position to found and create a real sexual ethics, which will clear away the hypocritical and even harmful repression of our generation. Certainly this reconstruction of ethics by the analysis of the social guilt feeling at first, of course, must start with the freeing of the individual. From that it will have to lead on to a new conception of the task of education before it will be in a position to reform legislation and the administration of justice in the light of the new knowledge of the unconscious psychical life.

So the natural sciences and the standards fixed by law have been much more resistant to the influence of psychoanalysis than the material with which they deal. For this reason I have given here less attention to the theoretical importance of

psychoanalysis for the sciences than to its practical influence, of which there are certainly already evidences in our individual and social lives. This fact seems to me to throw an interesting psychological sidelight on scientific work in general and on scientists, who as human beings are naturally dominated by their unconscious emotions like other human beings. Psychoanalysis first made intelligible the effect upon scientific investigation of motives that are not quite conscious. This influence of the unconscious upon the work of scientists may perhaps seem less obvious to you than its influence upon the production of artists. You would probably accept without question the revelation of psychoanalysis that the world views of former times and of former periods of culture were definitely created by the unconscious, especially as we can refer to such indisputable material as the mythology of civilized nations or the superstitious beliefs of primitive folk. But let us not forget that psychoanalysis has shown also how large an element of superstition there is in the unconscious of all of us. This expresses itself not only in many unpretentious symptomatic and sacrificial actions, but also in the great longing for occultism which at present is spreading over the Western world from the Orient. The same thing holds true for the archaic ideas expressed in mythology, which not only took root in the environment and particular generation that gave them birth, but are rooted also in our own unconscious, as psychoanalytic observation of the insane has proved from the archaic form and content of their phantasies. Both groups of ideas—the superstitious as well as the mythical—go back finally to an animistic conception of the world corresponding to the infantile omnipotence of thought. This conception was recognized by psychoanalysis as an overestimation of psychical reality as opposed to objective reality.

But if art, religion, philosophy, represent a reflection of the unconscious psychical life of man much more than a reflection of the outside world, one might say of the modern natural sciences that their peculiar value consists in their attainment of an ever clearer knowledge of reality. We must admit to ourselves, however, that we are less completely emancipated from the influence of animism than some of us think or than is perhaps possible. Probably even yet our scientific world

view is in part a projection of our own unconscious. And a conscious comprehension of this, such as psychoanalysis can give, will help us to make very necessary corrections in our knowledge of reality. This must be preceded certainly by a deeper self-knowledge, which will place us in the position of recognizing how far we have falsified reality by projection of the unconscious. In this connection I have made an interesting discovery which perhaps may throw a new light on the relation of science to the scientist himself and to his object, the outer world. I have been able to point out from analytic experiences that a large part of what has become reality for man to-day—that created by him, his so-called culture—is to a great extent also created by projection. As an illustration of that process of projection we may refer to the Biblical creation of man, who was supposed to be created in the image of God. But surely man created his God after his own image! This realization, in my opinion, explains also a process enormously important for the whole production of culture—namely, symbol formation. The scientific importance of these facts can perhaps be formulated in an extreme way thus: Every possibility in man of acquiring knowledge, even as every capacity of his psychical apparatus in general, reaches only so far as consciously to recognize—or rather re-recognize—what in the outer world man himself originally unconsciously projected into it. Thus we shall recognize again and again only ourselves in all science, will find always only ourselves in reality. Psychoanalysis has now broken through this vicious circle, at one point, by throwing back this process of recognition, sterile in a certain sense, from the outer to the inner without thereby losing itself in speculation. Psychoanalysis has never lost its hold on reality; rather it has constantly striven for a better understanding of just this relation between the inner and the outer world, with the aim of bringing about in this way a perfect harmony.

So psychoanalysis plays a part in biological development by making possible a better adjustment to the outer world through an immense extension of consciousness in the direction of our own inner psychical life—namely, the unconscious. In the same way, the psychoanalytic enlightenment of the neurotic may be considered as an artificial support to con-

sciousness—an intellectual prothesis, so to speak—in the fight against his too powerful unconscious, which prevents him from getting adjusted to reality. The extension of consciousness in general accomplished by psychoanalysis can be understood only in the sense of an advance in culture, as a perfect tool with which to obtain a better domination of one's own ego and subsequently of the outer world. It is my belief that psychoanalysis may be considered of the same importance in the intellectual development of man as the discovery of implements was to his cultural development. And we of to-day can as little foresee the consequences of this advance as primitive man could foresee the development of modern technique from his rude implements.

Yet at the end of our arguments let us turn again from the glimpse into a far future back to the present and to real life. We have not as yet progressed so far with the analytic process of attaining knowledge as to understand ourselves in relation to the culture that we have created, or even to withdraw ourselves from its pressure, sometimes unbearable. So far we have gained only the first insight in this direction, from which may develop a kind of psychological theory of relativity which will teach us to recognize and to avoid the subjectively conditioned sources of error in our attitude toward the world. For the time being, the sciences have succeeded in avoiding such sources of error only to a slight degree because they have always remained some way behind irresistibly developing life.

I hope my arguments have done something to convince you that psychoanalysis has enabled us to avoid these drawbacks of the theoretical sciences. If so, I trust that the psychoanalytic science itself will be spared the same fate of being subjectively misinterpreted or blocked by resistances in its attempt to throw light on the unconscious processes at work even in the sciences, which only then will become really objective.

ONE HUNDRED DOMESTIC-RELATIONS PROBLEMS

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THE psychopathic clinic of the recorder's court, Detroit, has for the past five years received, among the criminal cases referred to it for examination, cases from the domestic-relations division of the probation department of the court. Since the recorder's court is a court of criminal jurisdiction, the so-called domestic-relations cases are cases in which a husband or wife stands charged with, or has been convicted of, a felony or misdemeanor and in which the husband or wife is usually the complainant, or in which it is very apparent that the domestic situation is an important factor in the crime. When a husband or wife who is a defendant in such a criminal action is referred to the psychopathic clinic by the trial judge or by the domestic-relations division of the probation department, it is the custom of the clinic to examine the mate as well as the defendant. This is deemed necessary in order to understand as fully as possible the fundamental factors in the domestic maladjustment that are playing a part in the immediate situation with which the court has to deal.

Two hundred cases, one hundred men and their wives, form the basis for this observation. The cases have been selected at random from the files of the clinic during the last eighteen months, and are believed to be typical of the group of domestic-relations cases found in the criminal-court docket.

The technical charge for the criminal action in this series is shown in the following table. In each case of this series the husband was the defendant, although it has occurred in our experience that the wife has been the defendant. These charges are significant inasmuch as they classify the situation from a legal standpoint and epitomize situations which the psychiatrist recognizes as phenomena resultant from deeper underlying causes.

Non-support	36
Disturbing the peace	37
Assault and battery	20
Drunkenness	6
Indecent exposure	1
Total	100

As indicated in this table, the maladjustment in the 200 cases distributed itself, in 93 per cent of the cases, under the three charges of non-support, disturbing the peace, and assault and battery. In non-support cases the condition usually extends over a long period of time, and the warrant is finally secured by the wife upon the advice of outside parties or after some acute circumstance in the marital turmoil. Disturbing the peace is a charge that is very loosely applied, but it usually refers, in this series of cases, to an acute disturbance that annoyed the community or that came to public notice. The assault-and-battery charges were always the result of a fight between husband and wife.

When the cases are grouped by nativity, the proportion of those born in the United States is found to be somewhat larger than might be expected. Nine per cent of this group are colored, while the colored population of Detroit was shown to be 6.6 per cent at the time of the last census.

Nationality	*Men*	*Women*	*Per cent of total group*
United States	63	62	62.5
Canada	10	9	9.5
Poland	10	11	10.5
Ireland	3	4	3.5
Austria	3	2	2.5
England	1	3	2.0
Germany	2	2	2.0
Belgium	1	1	1.0
Roumania	1	1	1.0
Russia	2	2	2.0
Lithuania	2	2	2.0
Hungary	1	1	1.0
South Africa	1	0	.5
Total	100	100	

Since Detroit is on the border of Canada and has a very large Polish population, the large proportions of Canadians and Poles is to be expected.

A chronological-age distribution of the cases shows that the ages of this group range from 15 to 64 years. For the men the

range is from 20 to 64, with a median chronological age of 31.05 and for the women the range is from 15 to 64, with the median chronological age 32.8.

Of quite as great significance as the chronological age is the mental age of the individuals in this group. This was determined by the Pintner-Patterson tests, in the case of those who were illiterate, and by the Stanford abbreviated scale in all other cases. The group presents a range in mental ages from 6 years, 1 month, to 17 years, 4 months. For men the range in mental ages is from 7 years to 17 years, 3 months. For the women the range is from 6 years, 1 month, to 17 years, 4 months. The median mental age for men is 11 years, 7 months; for women, 10 years, 9 months. The women show a wider range than the men, both in chronological and mental ages, and the median age for the women in both cases varies about a year from that of the men. The women's median chronological age is 1 year, 8 months, higher than that of the men, and the median mental age of the women is one year lower than that of the men. The distribution of the intelligence quotients for the 200 cases shows a range for the men from 43 to 107, with a median of 68.6; for the women a range from 38 to 110, with a median of 62.8.

The grades attained in school are shown in the following table:

Grade	*Men*	*Women*	*Total*
First	0	0	0
Second	2	2	4
Third	3	4	7
Fourth	5	3	8
Fifth	11	8	19
Sixth	7	7	14
Seventh	10	9	19
Eighth	22	22	44
Ninth	5	6	11
Tenth	1	2	3
Eleventh	1	4	5
Twelfth	6	1	7
Special ungraded	1	1	2
Foreign	16	21	37
Illiterate	9	9	18
Seminary	1	0	1
College	0	1	1
	100	100	200

It will be seen from this table that, so far as school attainment is concerned, these cases do not differ greatly from the average.

The following table lists the occupations in which these individuals had been most frequently employed. One is impressed with the relatively high types of employment and the relative infrequency of unskilled work.

Men		*Women*	
Accountant	1	Cigar worker	1
Bricklayer	1	Dressmaker	2
Body builder	1	Housewife	89
Bench hand	1	Janitress	1
Barber	1	Laundry worker	1
Bartender	1	Milliner	1
Butcher	1	Nursemaid	1
Cook	1	Stenographer	1
Chauffeur	1	Tailoress	1
Core maker	1	Teacher	1
Clerk	4	Waitress	1
Carpenter	4		100
Decorator	2		
Die maker	1		
Electrician	3		
Factory hand	14		
Foreman	1		
Fireman	1		
Grinder	3		
Insurance agent	2		
Lather	1		
Laborer	12		
Machinist	8		
Millwright	1		
Machine operator	4		
Plumber	1		
Presser	1		
Painter	7		
Plasterer	3		
Peddler	2		
Real estate man	2		
Rag worker	1		
Radiator repairman	2		
Steamfitter	2		
Stationary engineer	2		
Tool maker	2		
Undertaker	1		
Varnish rubber	1		
Water tender	1		
Woodworker	1		
	100		

It appears that in the matter of employment this group approximated the average and exhibited no marked deviation that could account for unusual tension in the matter of economic adjustment. Even in the cases of non-support, employment was present, although in most cases it was shown to be intermittent.

The fact that 89 per cent of the wives were not employed outside of the home is evidence that the men were in the habit of providing a living of some sort.

Stress has sometimes been placed on youth at the time of marriage as a cause of domestic difficulty, but a survey of this group from this point of view shows that the range in chronological age for the men was from 18 to 44 years with a median age of 23.38 and for the women from 14 to 44 with a median age of 20.4. These medians approximate the median age for marriage in the average unselected group. Consequently, the age at the time of marriage seems, in this group of cases, to be of relatively small significance.

Another observation that might appear contrary to popular belief is the subordinate place that the size of the family holds as a factor in the domestic difficulty. Sixteen per cent of these couples had no children at all and of the remaining 84 per cent, the median number of children was 1.5. Apparently the burden of raising a large family was not a main factor in the friction in these homes.

The tabulation of the clinic's diagnosis of each of these 100 husbands, beside that of the wife, is regarded as of interest and significance and is recorded below. In this table the term "psychopath" refers to that poorly defined group classified under the heading "constitutional psychopathic state" or "psychopathic personality". The term following "psychopath" in this table refers to the most prominent trend or trait of the psychopathy. "Chronic alcoholic" is applied only to those individuals who show deterioration from alcoholic excess. "Inferior" is applied to those whose intelligence quotients are below 75 and who manifest inferior types of behavior. "Feebleminded" refers to individuals whose intelligence quotients are below 60 and whose behavior leaves no doubt as to the presence of a mental defect. "Unclassified" is a term used for cases of definite neuropsychiatric

disorder which do not fit into any of the usual classifications. These diagnostic classifications, while not intended as especially interpretive, do indicate the very great frequency of psychiatric deviations present in this type of problem.

Husband	*Wife*
1. Chronic alcoholism	Inferior
2. Inferior	Inferior
3. Psychopath, inadequate	Psychopath, unstable
4. Inferior, chronic alcoholic	Psychopath, egocentric
5. Neurosyphilitic with alcoholism	Feebleminded
6. Inferior with alcoholism	No psychiatric deviation
7. Psychopath, inadequate	Psychopath, unstable
8. Psychopath, egocentric	Psychopath, unstable
9. Inferior	No psychiatric deviation
10. Inferior; anxiety state; right testicle removed	No psychiatric deviation
11. Inferior	Inferior
12. Psychopath, egocentric	Inferior
13. Chronic alcoholic	Psychopath, inadequate
14. Chronic alcoholic	No psychiatric deviation
15. Psychopath, egocentric with pulmonary tuberculosis	Inferior; old leg ulcer
16. Chronic alcoholic with bronchial asthma	Psychopath, egocentric
17. Inferior with chronic alcoholism	Inferior
18. Unclassified	No psychiatric deviation
19. Chronic alcoholic with paranoid trend	Inferior, with neurosyphilis
20. Psychopath, inadequate	Epilepsy
21. Inferior; alcoholic with paranoid trend	Inferior, with chronic endometritis
22. Psychopath, egocentric	Psychopath, unstable
23. No psychiatric deviation	Inferior
24. Psychopath, inadequate	No psychiatric deviation
25. Psychopath, inadequate	Inferior
26. Chronic alcoholic	No psychiatric deviation
27. No psychiatric deviation	Inferior
28. Chronic alcoholic	No psychiatric deviation
29. Chronic alcoholic	Inferior
30. Feebleminded	Inferior
31. Feebleminded	Feebleminded
32. Chronic alcoholic	Inferior
33. No psychiatric deviation	Inferior
34. Inferior	Inferior with marked irritability
35. No psychiatric deviation	Inferior
36. Chronic alcoholic	Inferior
37. Chronic alcoholic with epileptic seizures	Inferior
38. Inferior	Inferior

Husband	*Wife*
39. Psychopath, inadequate, with syphilis	Psychopath, unstable, with syphilis
40. Inferior	Inferior, alcoholic
41. Inferior, endocrinopathy	Inferior
42. Chronic alcoholic	Feebleminded, psychoneurotic reactions
43. Feebleminded, chronic alcoholic	Inferior
44. Chronic alcoholic	Inferior
45. Chronic alcoholic with paranoid trend	No psychiatric deviation
46. Inferior, with psychotic episodes of unclassified nature and gonorrhea	Inferior
47. Chronic alcoholic	Psychopath, inadequate
48. Neurosyphilis with epileptiform seizures	Psychopath, unstable
49. Inferior, chronic alcoholic	Inferior
50. Inferior	Inferior
51. Inferior, with alcoholism and syphilis	Inferior, with vascular neurosyphilis
52. Chronic alcoholic	No psychiatric deviation
53. Chronic alcoholic with syphilis	No psychiatric deviation
54. Psychopath, unstable	Inferior, with epilepsy
55. Chronic alcoholic	Psychopath, unstable
56. Chronic alcoholic	Inferior, with encephalitis lethargica residuals
57. No psychiatric deviation	Psychopath, unstable
58. Psychopath, egocentric	No psychiatric deviation
59. Chronic alcoholic	Inferior, with psychoneurotic reactions
60. Feebleminded	Feebleminded
61. Psychopath, inadequate	Inferior
62. Chronic alcoholic	Inferior
63. Inferior with alcoholism	Inferior, very unstable
64. Psychopathic, inadequate	Inferior
65. Inferior with alcoholism	Inferior, psychoneurotic reactions
66. Chronic alcoholic	Psychopath, unstable
67. Chronic alcoholic	Inferior
68. Inferior	Inferior
69. Chronic alcoholic	Inferior
70. Inferior	No psychiatric deviation
71. Chronic alcoholic, hallucinosis	Inferior
72. Psychopathic, egocentric	Inferior
73. Neurosyphilitic	Unclassified
74. Inferior, with pulmonary tuberculosis	No psychiatric deviation
75. Inferior with alcoholism and gonorrhea	Inferior
76. Chronic alcoholic	Psychopath, unstable, with psychoneurotic reactions
77. Alcoholic, with neurocirculatory asthenia	Inferior
78. Inferior	Inferior, with hyperthyroidism

Husband	*Wife*
79. Inferior	Feebleminded
80. Chronic alcoholic	Inferior
81. Dementia praecox	No diagnosis, incomplete
82. Chronic alcoholic with syphilis	No psychiatric deviation
83. Unclassified — possible situational depression, possible dementia praecox	Disglandular syndrome, with hypopituitarism
84. Chronic alcoholic	No psychiatric deviation; chronic endometritis
85. Chronic alcoholic	Possibly hysterical abulia; alternative—dementia simplex
86. Chronic alcoholic, with paranoid trend	Hysteria
87. Inferior, with gonorrhea and syphilis	Inferior, with syphilis
88. Psychopath, egocentric	Psychopath, unstable
89. Psychopath, unstable	Conversion hysteria
90. Feebleminded	Psychopath, unstable
91. Chronic alcoholic	Inferior, with psychoneurotic reactions
92. Inferior, with syphilis and mixed phagadenia	Inferior
93. Inferior, chronic alcoholic	Feebleminded
94. Inferior, chronic alcoholic	Inferior
95. Inferior, chronic alcoholic	Inferior, with deterioration from undetermined toxemia
96. Chronic alcoholic	No psychiatric deviation
97. Chronic alcoholic	No psychiatric deviation
98. Inferior, chronic alcoholic	Inferior
99. Psychopath, inadequate	No psychiatric deviation
100. Inferior, chronic alcoholic	Inferior

In every pair there is some psychiatric deviation and this uniformity of occurrence is so striking as to challenge the attention in any attempt to understand the nature of the problem presented by these cases. Although in this series the husbands were the defendants in court, the wives present nearly as much mental deviation from the average as the husbands. This emphasizes the necessity of examining each mate.

Attention is invited to the great frequency of alcoholism among the men. It was present in 48 per cent of the cases in sufficient degree and kind to merit special mention. Inferiority and feeblemindedness were noted in 56 per cent of the wives. These two factors are regarded as especially significant. In our observation, an inferior wife is an extremely

frequent selection of the alcoholic male. After the marriage the poor home management and inferior economic judgment of the inferior wife tend to urge the alcoholic husband into further alcoholism. This is often an extremely important factor to be borne in mind in the attempts at supervision of alcoholic husbands who come before the court on some charge or other growing out of their domestic situation.

A few examples of the types that make up this domestic-relations problem in a criminal court may be mentioned.

There is the case of a twenty-four-year-old husband charged with non-support. He has been married two years, has worked only very irregularly, and has never supported his wife. He manifests an intelligence quotient of 86, but, as a result of poor early training, shows an utter lack of any sense of social responsibility. We regard him as an inadequate type of personality, one of the so-called psychopaths, inadequate type. His wife, who is twenty-eight years of age, has an intelligence quotient of 59. She came from a family of very poor stock and, at the time of our examination, had gonorrhea and frequent epileptiform seizures. There was constant quarreling in the home over the care of the one child and constant interference on the part of the husband's mother.

Another example is that of a thirty-two-year-old man who was brought into court on a charge of assault and battery. He struck his wife when she came home in the early hours of the morning accompanied by another man. Investigation showed him to be heavily alcoholic and especially abusive when drunk. Examination revealed the absence of the right testicle and evidence of a mild anxiety state on the basis of that deformity. His intelligence quotient was 59 and he was illiterate. He had been married ten years to a woman who was also alcoholic, who had had an illegitimate child since her marriage, and who frequently left her husband because of family interference. She showed, upon examination, an intelligence quotient of 81.

Next is a forty-six-year-old man, with an intelligence quotient of 62, who was a widower at the time of this marriage, eighteen years ago. He was in court for non-support, due to irregular employment as the result of his alcoholism. His

wife, thirty-six years of age, presented an intelligence quotient of 61, and her history indicated that she had come from the most slovenly and undesirable of homes. She had had an illegitimate child by another man prior to her present marriage and she was an exceedingly poor manager.

Still another case is that of a twenty-nine-year-old man, with an intelligence quotient of 69, who was before the court for disturbing the peace—in other words, for fighting with his wife. He had been arrested eight times before and at the time of our examination had an active gonorrhea. His history indicated that he had been raised in an orphanage after the separation of his parents in his early childhood. He had been a tramp and had been excessively alcoholic. His wife was twenty-eight years of age and presented an intelligence quotient of 62. They had been married ten years. The wife had been very promiscuous sexually throughout her girlhood and was pregnant at the time of their marriage. This family's chief difficulty was attributed to interference on the part of her relatives, although it is obvious that there are other factors that prevent a happy adjustment.

The next case is that of a thirty-nine-year-old man, with an intelligence quotient of 79, heavily alcoholic, irregular in his work, and abusive to his wife, especially when drunk. He was married thirteen years ago to a woman, now thirty-two years of age, who is illiterate and has an intelligence quotient of 50. Their marriage was forced by the priest who knew of their having had sexual relations. The wife has had many periods of hysterical disability in the form of paralysis, blindness, and other conversion phenomena.

These few examples serve to indicate the complexity of the problem as it presents itself to the court. The legal charge and the legal provisions, therefore, fall far short of bringing about harmony in the home and hence solving the domestic problem. It is instantly apparent that a tremendous amount of psychiatric effort and of social supervision would be necessary even to approximate a solution of problems of this type, and of course it goes without saying that many of them are unsolvable with the agencies at our disposal.

It is not our intention here to offer a panacea for domestic ills, but only to point out that every domestic-relations case that presents itself at court warrants as full and complete an investigation of the wife as of the husband, and that when this is done, practically every problem is shown to be one of extreme complexity, requiring very long and careful therapy and not to be settled by the administration of a fine or a short term of imprisonment.

1926 EMPHASES IN PSYCHIATRIC SOCIAL CASE-WORK

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PSYCHIATRIC social work is one of the youngest, if not the youngest, specialty in the field of case-work. Because of its youth, it has but little cumulative experience from which to guide its future, yet, like all other lines of work, it has the opportunity to benefit by the experience of allied projects and it has above all the obligation to stop now and then and take stock. Many phases of its work deserve consideration and many are being accorded the attention of its leaders.

The 1926 emphases, it seems to me, fall into three groups, relating respectively to (1) the social worker, (2) treatment, and (3) the record. Let us consider them in order—first the social worker. It may be wondered why the social worker is demanding attention since the necessity for adequate training and rich life experience has long been recognized. These points are not in question now. In fact, professional standards of training are growing gratifyingly higher. It is the social worker's own emotional life that is giving leaders in the field concern. The query is, What emotional attitudes does the social worker bring to her cases? What is a particular social worker's capacity for securing an intimate enough contact with the patient and his family to allow for good case-work, and in how far is there danger that her contact may result in an identification of her own personal problems with those of the patient and thus result in a loss of proper perspective? For example, the social worker whose own unhappy home life results in a deep antagonism to her father is frequently completely unable to see the "father" and his place in the scheme of her case-work other than as an obstruction and a source of danger. Swings in the religious lives of some social workers from the rigid conservatism of early childhood to liberalism make them impatient with the client's adherence

to creed and blind to the possibilities of using his religion as an integrating force. Prejudices—social, sexual, religious, and racial—result in a detachment that prevents frankness.

Many workers, on the other hand, become too much absorbed in one particular aspect of the case or in one particular member of the family, and lose sight of the total situation. Take, for instance, the not uncommon attachments of adolescent members of families to the social worker, which, if allowed to go uncontrolled, result in partiality to the favored one and in consequence a split in the family ties. I recall the case of a fifteen-year-old boy of only average ability who was being harassed to death by the almost constant nagging of his high-strung, ambitious mother because he failed to succeed in academic subjects as his brilliant older brother had done. The boy's situation was extremely pathetic and temporary removal from home was advised by the examiners. Instead, however, of waiting to bring the mother to a positive attitude of accepting or rejecting the plan, the worker, because of her sympathy for the boy, allowed him to know the clinic's recommendation, which resulted in a serious break in the family and a complete failure of the plan. The degree of the social worker's identification with the client or problem must always be under control—sufficiently intimate to get the confidences and personal shades of the whole family, yet sufficiently detached to get a proper perspective.

It is a question whether or not social workers can do anything more than be consciously aware that their own emotional attitudes, if not understood and controlled, may dangerously block the successful handling of a case. Staff conferences on the progress of cases should check and bring to light wrong approaches and unhealthy degrees of attachment. I am inclined to think, however, that in these conferences we have given most of our attention to the client's failure to accept our program and very little consideration to the way in which the program was presented to him. Generally only gross mishandlings are discovered in these conferences; rarely do "feeling tones" or the attitudes of the worker come out. Feverish, offhand statements made around the office—such as "Mary is a fine girl; the trouble is *all* with her mother!"—are perhaps our best index at present to the feeling tones of

workers toward their respective clients. Some one has facetiously advised a psychiatric examination for all social workers, the results to be on file in her immediate position. Perhaps this suggestion should be regarded more seriously, or, lacking this, might we not look to the establishment of some emotional test that would help us here? Present experimentation with such tests is already being carried out with sufficient success to indicate that this is more than a remote possibility. And, after all, is the problem of evaluating emotional attitudes any more elusive than the problem of measuring intelligence was in 1905? In the meantime, we should individually keep in mind the fact that the success or failure of our case-work is tremendously affected, and very subtly so, by our own emotional attitudes and our own personal biases.

Our second emphasis—upon treatment—lends itself to more tangible considerations. According to the leaders in psychiatric social work, more treatment is absolutely essential. More treatment does not necessarily mean more plans in the way of physical facilities for solving problems; it means more thorough follow-up work and a juster evaluation of the plan that grows out of the original diagnosis.

Medical dispensaries, special schools, settlement houses, libraries, summer camps, and so forth, are not ends, but means to an end—the adjustment of the individual. If case-work means anything at all, it means helping an individual to solve a problem that he is not able to meet unaided. Elaborate programs are meaningless in the majority of cases unless they are followed through. The new situation, even if accepted by the client, needs explanation and interpretation. Take, for example, the nervous, anxious mother who comes into conflict with her adolescent son, aged fourteen, because she refuses to allow him to attend a swimming class lest he come to some harm. The boy revolts, grows constantly more irritable, and adopts a negative attitude toward all of his mother's demands. The mother's acceptance of the suggestion that the boy be allowed to enroll in a swimming class at a neighboring settlement house does not solve the problem. It is the mother's nervous, apprehensive attitude that must be worked with if we are to effect anything of lasting value. Further, how far should the boy be made to understand his mother? Is there

not grave danger that he may interpret his mother's submission to the swimming class as a victory for himself and in consequence strut forth in high-handed fashion against all manifestations of authority? If, through case-work treatment, we hope to prepare our client to meet the subsequent realities of life, he needs to be carried beyond the initial acceptance of a program.

These are unquestionably, however, degrees of difficulty in the treatment of cases. Because of the level of intelligence of certain parents and because of their stable emotional state, one is often able to secure almost complete acceptance of a program from the start. Situations and cases of this kind require only what Porter R. Lee calls the executive type of treatment, demanding that the social worker be alert to the needs of her client and the resources of the community for satisfying those needs.

It is the more complex situations that challenge a social worker's skill as a case-worker. Such situations challenge her ingenuity in securing confidence, her knowledge of human behavior, her trained intellect in seeing and revealing the subtle shades that mark off causation factors, and, finally, her ability to cope with long-standing attitudes and prejudices. Coping with attitudes and prejudices is, it seems to me, the most difficult task that the trained social worker has to meet, and the extent to which she is able to meet it is the criterion of whether treatment has been effected.

In the case treatment of a child-guidance-clinic patient, the mother is rarely, if ever, left out, but the father is frequently not considered. Somehow we have the habit of forgetting that he counts, other than to be prescribed for through the mother. Too often he is completely neglected. He is expected to adjust to the plan inaugurated without any consideration of his capacity or his desire to do so. His importance is never forgotten in theory, but, alas, in practice he is seriously overlooked! Time should be allowed for seeing all members of the family and all other persons outside the family (connected with school or work) who seem indicated in the preparation of the social history and in the progress of the treatment.

Teachers should not be disregarded. How many social workers get anything more than bald statements as to the

status (good, fair, or bad) of their client from the teacher? In many cases the teacher's attitude and handling of the child is the crux of the situation. Take, for example, the following case: Earl, a twelve-year-old boy, was referred to a clinic because of his violent temper outbursts. In school he pinched other children and was saucy and defiant. One day, in an attempt to open the locked drawer of his portable seat, he tipped it—and reaching over to his neighbor's desk, took his pen and dipped it into the inkwell in order to satisfy himself as to how far he could tilt his desk without spilling the ink; then he laid the inked pen on the neighbor's desk. The teacher was irate, and particularly objected to the fact that Earl had placed the inked pen on his fellow's desk. Instead of learning the boy's reason, she ordered the neighbor to wipe Earl's face with the pen. How far can one hope to get in a case such as this without tackling the attitude of the teacher?

Perhaps less obvious, yet just as serious, is the teacher's attitude in the case of Richard, a nine-year-old boy who was doing unsatisfactory work in the third grade and who had failed to be promoted the semester before. The school was dubious about his mental ability. He had not finished a single arithmetic paper for the semester and he was extremely slow in all of his reactions. He was absent-minded and at times seemed completely oblivious of the persons or things about him. He would rise and walk aimlessly around the room in the middle of an interesting story. Parents feared a mental break because there was insanity in the family background. Clinical study revealed the fact that Richard was a boy of very superior ability and that he had an absorbing interest in knights. He drew one in perfect detail and executed a complete replica of a feudal castle in the sandbox at the clinic as he waited for the examiner. He was sensitive about his slight build and volunteered that "any kid in the school could lick him". He read, lived, and dreamed of knights, and from them he was getting the color, self-expression, and satisfaction that he had not been able to secure otherwise. The task of the social worker was evident when she reported the findings to the teacher, who, with a disgusted air, announced that "it made no difference; everything with Richard was knights". She did not see the tremendous motivating power of this

interest. She did not see that it had the danger of a growing escape from reality and that her attitude was enhancing the likelihood of the boy's pursuing it. Next to the home—and I sometimes believe more than the home—the school exercises a profound influence on the child's personality. And in this drama the teacher is not the least actor. If she is understanding and sympathetic, she can do an infinite amount in the way of making a child happy. No other person has such an excellent opportunity to draw out the sensitive, seclusive child; no one has such an excellent opportunity to put the ruthlessly aggressive child into situations that demand control and sportsmanship. The social worker should work hand in hand with the teacher.

Older brothers and sisters are often unplumbed resources. They are frequently able to throw amazing light on the family situation and in not a few cases are very important factors in the problem that the younger brother or sister presents. Differences in age, differences in ability, and differences in interest pile up to augment the failure to understand. The family's pace in educational accomplishments is generally set by the older children, and life is made miserable for the child who is unable to keep up to it. Many serious kinds of behavior prove on investigation to have had their onset in the younger child's first failure to realize the educational goal set. I recall a most dramatic runaway case, accompanied by lying, seclusiveness, and negativism, in a fifteen-year-old boy whose life had been made wretched because he did not keep pace with his brother two years older, an honor student at a university, and his sister, aged eighteen, a sophomore in an Eastern college. If we are to hope for maximum efficiency and happiness, all the members of a family must respect and appreciate one another's abilities, and all the interrelationships in family life must be taken into account.

Let us now consider the record, which seems to me to be the third point of emphasis in the field of psychiatric social work. The topical history *versus* the chronological has been considered pro and con by psychiatric social workers. The topical form is of particular value to the examiners, while the special merit of the chronological form lies in the fact that it reveals the interplay of social worker and client, and

if completely written, gives the more honest picture of the client. The consensus of opinion is in favor of the topical form, with a special section set off to recount the conditions under which the data were given and what devices in interviewing had to be resorted to in securing the history.

How to make the record of the greatest possible service to the particular case and at the same time a valuable instrument in the field of scientific research is a more challenging problem. To be able to lend itself to statistical research, the record must contain negative as well as positive information about a wide range of topics in the field of sociology, psychology, and psychiatry. The possibility of wearying the patient and thus distorting the report immediately rises. And more serious still is the great likelihood of antagonizing him by what he regards as an inquisition. He has come with a particular problem and can rarely see the significance of hundreds of questions. Time, energy, and greater ingenuity in interviewing would be the demand on the social worker if the record were completely to satisfy such a standard. There is perhaps a solution—a statistical face sheet which could be filled out on a second visit, after contact had been established. To be of greatest validity, it should be filled out before any examinations. At the present time psychiatric social histories are for the most part service records to the client—portraying as honest and as complete a picture of the client and his difficulties as the social worker is able to get.

As case-workers, we are primarily interested in the treatment phase of the record, since it is in treatment that case-work, at its best, begins. The treatment entries in the child-guidance-clinic records contain for the most part meager statements of what was done. Rarely do they tell how the social worker worked—how she met the client's objections, how she secured the patient's confidence, and so forth—and yet it is the ability to secure confidences and meet objections successfully that distinguishes the social case-worker from the "intelligent, sympathetic, socially minded layman".

Take, for example, the following treatment entries: "Visited Dr. Brown [the patient's father] for the purpose of enhancing his interest in summer camp for Robert. Finally persuaded him, and he agreed on Camp Orano"; or, "Home

visited. Talked with mother a long time on the need of tonsillectomy for Mary. She agreed it should be done and promised to have it done before school opens''; or, ''Mother's opposition to dancing for Bill was talked out. The desirability of adequate recreation was stressed. She was voluble and stated her lack of sympathy with modern amusements for young people in no uncertain terms. She promised to visit the next dance at the settlement house and see for herself.''

Any of these entries indicate much in the way of an exchange of ideas between the beginning of the interview and its close. Take the last: How did the worker get the mother to promise to visit the next dance? What alternatives did she consider? No one knows.

According to leaders in the field of case-work, the problem is in our own hands. We must get behind the results, record the worker's thinking, and eventually accumulate enough data to tell how the social case-worker works. Porter R. Lee, before the Connecticut State Conference, April 1923, in a paper entitled *A Study of Social Treatment,* demonstrated with convincing clarity this imperative need, and to-day several national organizations are urging us to follow his proposed method of complete interview recording. Recognizing the element of time to social worker and stenographer, the child-guidance-clinics are asking their case-workers to carry a minimum number of cases on that basis, believing that the benefit that will accrue to the respective cases, to the social worker herself, and to the field of case-work, will outweigh any cost in time.

What progress can be made in any one of the lines I have cited can hardly be forecast. That these and many other aspects of our work are commanding the attention of serious thinkers is in itself a good omen. Yet only from the assiduous labor of the case-worker, with her mind alert to new developments and her heart close to the project, can we look for real progress.

THE CONSTANCY OF THE I.Q. OF MENTAL DEFECTIVES

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IT is undoubtedly true that those who are associated with our children, our delinquents, and our dependents are more and more coming to a realization that intelligence-test scores are not the final consideration in making a diagnosis or in planning the training of an individual. At the same time they accept the fundamental importance of intelligent interpretation of these tests, which have become so generally used in the last few years. Consequently, any question concerning the tests is of interest not only to the psychologist and the psychiatrist, but to the general physician, the social worker, the school-teacher, and the parent.

One of the most frequent as well as the most important questions raised has to do with prognosis: Does the intelligence quotient remain constant throughout life? It seems safe to assume that the I.Q. is constant for the average child. The very existence of the tests proves that. That is, the average child of four years has a mental-test age of 4 years; the average child of seven years has a mental-test age of 7 years; and so forth. "Uniform" mental development is implied also by the uniform progress in school that characterizes the average child. And the studies along this line that have been made thus far lead us to the same conclusion. As there exists no real criterion for determining the rate of mental development, we have arbitrarily designated as "uniform" that which is known to be true of the greatest number. It is not, however, these "average" children, but rather the deviates, the subnormal and the supernormal, who constitute the greatest problem in the social and educational systems. And it is in regard to these exceptional children that we ask most frequently, "Will their I.Q.'s remain constant?" It is obvious that if we could prophesy the ultimate intelligence, at least

quantitatively, we could guide more wisely the training of the individual.

With this problem in mind, a study was made of 441 feeble-minded persons, all inmates of Letchworth Village. These patients were tested on admission and reëxamined after a period of time varying from two to ten years. All this work was done by trained examiners, and the retests were in each case made by the writer. Unfortunately for the purpose of this study, in 45 cases—or 10 per cent of the total number—the Goddard revision of the Binet-Simon was used for the first examination, but on all subsequent occasions Terman's form was given. The Goddards were transposed into Termans by recording on a Stanford-test blank the responses made on the Goddard test. As all these 45 cases were of imbecile grade it was possible, by crediting the alternates, to secure a complete Terman rating. The mental ages on the transposed tests were invariably lower. Intelligence quotients were then figured on the Goddards as well as the Termans and were of course higher. The median difference in I.Q. of the two groups was 5.5 points. As a check on this, the Goddard and Terman were given together at the time of retest to 15 of the 45 patients. Here, too, the Goddards rated the patient higher, the median difference in I.Q. being 5.0 points. This difference, occurring in tests given at the same sitting, seemed to justify the use of the transposed tests in this study.

The 441 cases were a group with I.Q.'s ranging from 20 to 70, unselected except for the fact that markedly psychopathic cases or patients with gross physical disability such as paralysis were thrown out. Obviously this was necessary because of the impossibility of securing an accurate test on such subjects. The following summary shows the amount of variation in the intelligence quotients from the two examinations.

	Number	*Per cent*
No variation	48	10.9
Variation 1–5 points	268	60.8
Variation 6–10 points	85	19.3
Variation 11–15 points	21	4.8
Variation 16–25 points	19	4.3
	441	100.0

There is evident an inverse relation between the degree of change and the frequency with which it occurs. Slight changes are much more likely to take place than marked gains or losses.

Although it may well be questioned whether one point on the I.Q. means the same at all levels of the intelligence scale, experience indicates, and it is now generally conceded, that for all practical purposes a variation of five points or less may be ignored in studying the intelligence quotients of mental defectives. Considering, then, as constant all those cases in which the change is no more than five points, we get the following results:

	Number	*Per cent*
I.Q. constant	316	71.7
Gain in I.Q.	21	4.8
Loss in I.Q.	104	23.6
	441	100.0

The 21 gains range from 6 to 21 points, the 104 losses are from 6 to 23 points. The median gain is 6.6 points and the median loss 9.6 points. From these figures it appears that in 72 per cent of our cases the intelligent quotient remains constant. In 24 per cent there is a loss, and only 5 per cent of the total show a gain. Our figures also indicate that not only are the losses more frequent than the gains, but they are greater in amount.

It is interesting, too, to note that in only 40, or 9 per cent, of our cases is there a variation of more than ten points. If Letchworth Village patients can be considered as representative of the feebleminded as a class, we may conclude that in 72 cases out of 100, individuals with intelligence quotients between 20 and 70 will maintain that same I.Q., that in 91 cases out of 100 they are placed approximately on the intelligence scale and will gain or lose no more than 10 points, and that the small percentage who do change will probably lose rather than gain.

Although we have shown statistically that nearly 75 per cent of the time we can prognosticate successfully—that is, that intelligence quotients of from 20 to 70 will not vary more than 5 points when the mental test is applied to persons over

6 years of age with neither gross organic brain lesions nor psychopathic personalities—still, we are left with the uncomfortable realization that we can be wrong at least 25 per cent of the time and possibly make a wrong prognosis on just that case about which we particularly need to be right. Fortunately, family and personal histories were available on practically all the 441 patients and these were reviewed with the idea in mind that there might be something in the clinical picture that would furnish a suggestion whether the individual patient could be expected to maintain a constant intelligence quotient, to lose in I.Q., or to gain in I.Q. From the study of the clinical records, the cases were listed as follows on the basis of the probable cause of the mental defect:

1. Cases on which we had not *sufficient information* to draw conclusions.
2. Cases with a history of *familial mental deficiency.*
3. Cases in which chronic alcoholism, general immorality, habitual poverty, or other unsocial conduct *symptomatic of mental deficiency* was present in other members of the family.
4. Cases with family histories of *insanity or epilepsy.*
5. Cases of *negative heredity with personal histories of organic disorders,* such as trauma, toxic states, convulsions, or endocrine malfunction, followed by changes in development or mentality.
6. Cases in which *family and personal histories were apparently negative.*

The table on page 755 shows the distribution of these various etiological factors through the constant and the inconstant groups.

In 20.9 per cent of the 316 constant cases and in 14.4 per cent of the 125 inconstants, the information was insufficient to warrant conclusions. Of all the causative factors, familial mental defect occurs most frequently and to about an equal degree in the various groups, being present in 166 of the 316 constant cases, in 48 of the 85 cases with a variation of 10 points or less, and in 25 of the 40 with more than 10 points' variation. Familial symptoms suggestive of mental deficiency are observed in 24 of the constant group, in 11 of those varying from 6 to 10 points, and in 3 of the cases of more than 10 points' variation. Insanity or epilepsy are conspicuous

DISTRIBUTION OF ETIOLOGICAL FACTORS THROUGH CONSTANT AND INCONSTANT GROUPS

Etiological factors	TOTAL		CONSTANT I.Q.'S		INCONSTANT I.Q.'S							
					Total		*Variation 6–10 points*			*Variation over 10 points*		
	Number	Per cent	Number	Per cent	Number	Per cent	Total	Loss	Gain	Total	Loss	Gain
Insufficient information	84	19.0	66	20.9	18	14.4	12	11	1	6	5	1
Familial mental deficiency....	239	54.2	166	52.5	73	58.4	48	38	10	25	22	3
Conditions symptomatic of mental deficiency	38	8.6	24	7.6	14	11.2	11	9	2	3	3	0
Familial insanity or epilepsy.	9	2.0	8	2.5	1	0.8	1	1	0	0	0	0
Negative heredity with personal history of organic disorders	29	6.6	21	6.6	8	6.4	6	4	2	2	2	0
Negative family and personal history	42	9.5	31	9.8	11	8.8	7	6	1	4	3	1
Total	441	100	316	100	125	100	85	69	16	40	35	5

in the families of 8 of the constant cases and of 1 of the 6-to-10 points' group, and are found not at all in the third group. Where the family history is negative we find a personal history of trauma, toxic states, or other organic disorder in 21 of the constant group, 6 of the 6-to-10 points' group, and 2 of the cases varying more than 10 points.

To present these data in simpler form, the patients were then classified as belonging etiologically to one of two types, primary or secondary. As these terms, or types, are not specific and consequently are open to misinterpretation, it seems wise to explain just what they represent clinically to the writer. The primary type represents that group whose mental defect is due to low potentiality for development and a lack of the urge to carry development *per se* to completion. The secondary type represents that group of defectives whose potentiality for the development of intelligence is adequate, but whose development has been cut off, inhibited, or appreciably retarded as a result of accident or disease. Of the etiological factors named, only negative heredity with a personal history of organic disorders can be the criterion for classifying a case as of secondary origin. Those cases with positive family histories—*i.e.,* those with familial mental defect, familial symptoms suggestive of mental defect, and insanity or epilepsy in the families—are rated as primary. Those about whom the information was insufficient and those with negative family and personal histories are classed as unknown. The cases were divided between known and unknown as follows:

	Total	*Constant I.Q.'s*	*Inconstant I.Q.'s* Gain	Loss
Unknown	126	97	4	25
Known	315	219	17	79
Total	441	316	21	104

Subdividing the known cases into those of primary and those of secondary origin, we get these results:

	Total Number	Per cent	*Constant I.Q.'s*	*Inconstant I.Q.'s* Gain	Loss
Primary	286	90.8	198	15	73
Secondary	29	9.2	21	2	6
Total	315	100.0	219	17	79

It will be noted that 91 per cent of the total number of known cases were of primary origin and 9 per cent of secondary, and that the groups with constant and inconstant I.Q.'s each contain practically the same proportion of primary and secondary cases as are contained in the group of known cases as a whole. Apparently, therefore, it makes no difference in the constancy of the intelligence quotient whether the origin of the defect is primary or secondary.

The matter of sex differences seemed deserving of investigation. The following summary gives the results:

	Males		*Females*	
	Number	Per cent	Number	Per cent
Constant I.Q.'s	216	68.6	100	79.4
Loss of 6–10 points	54	17.1	15	11.9
Gain of 6–10 points	9	2.9	7	5.6
Loss of over 10 points	32	10.2	3	2.4
Gain of over 10 points	4	1.3	1	0.8
Total	315	100.0	126	100.0

From this it appears that the females tend to be more constant than the males, and that this variation of the males, like the variation in the group as a whole, tends to be a loss. Furthermore, the average loss in the males is greater than the average loss in the females.

The question of age next presented itself. In respect to age at the time of reëxamination, the 441 patients were found to be distributed as follows:

Age	*Total*		*Constant I.Q.'s*		*Gain*		*Loss*	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Under 12 years	59	100	37	62.7	2	3.4	20	33.9
12–15 years	153	100	99	64.7	4	2.6	50	32.7
16–20 years	123	100	89	72.4	8	6.5	26	21.1
21 years and over	106	100	91	85.8	7	6.6	8	7.6
Total	441	100	316	71.7	21	4.8	104	23.6

This table indicates that the greatest variation occurs in young children under twelve years, with a tendency toward greater constancy as the individual advances in age. This implies that the inconstancy is due to something in the individual rather than to errors in test procedure. It is interesting to note also that in the upper age levels the losses occur less frequently and the gains more frequently.

The mental level of the inconstant group was reviewed and shows practically the same distribution through the imbecile and moron levels as occurs in the rest of the study, and as we find in the institution as a whole.

SUMMARY

1. Of 441 feebleminded individuals of the imbecile and moron levels, 72 per cent showed no real change in I.Q. on reëxamination. Ninety-one per cent showed a variation of no more than 10 points.

2. The variation that appeared tended to be a loss rather than a gain.

3. There appeared to be no relation between the etiology of the defect and the constancy of the I.Q.

4. The males were more likely to vary in intelligence quotient than the females and their change tended to be a loss rather than a gain.

5. The greatest frequency of variation in I.Q. was in children under twelve years and the greatest constancy was in adults over twenty-one years of age.

6. There seemed to be no connection between mental level and constancy of the I.Q.

The number of cases included in this study seems sufficiently large to offset to a considerable extent the unfortunate feature of drawing conclusions from only one reëxamination of each case.

CONCLUSION

If the patients of Letchworth Village can be regarded as representative of the feebleminded class as a whole, we may feel that intelligence quotients of from 20 to 70 obtained by the use of the Terman test are constant in more than 7 cases out of 10, that females are more likely to be constant than males, and that should any variation occur, it will probably be a loss.

From the information so far available, there seems to be no explanation of the variation that does appear. The fact, however, that there are age and sex differences suggests immediately that there may be some connection between the variation and the rate of physical development. A study of the relation of these two in mental defectives is contemplated at Letchworth Village.

THE GREENE COUNTY MENTAL CLINIC

AN EXPERIMENT IN EXTENSION OF THE OUT-PATIENT SERVICE OF A PSYCHOPATHIC HOSPITAL INTO A RURAL COMMUNITY

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THE state of Iowa has chiefly a rural population with only one city of more than 100,000 inhabitants, and there are no psychiatrists available for consultation except those upon the staff of the state psychopathic hospital at Iowa City and those in private practice in some of the larger centers. Since the opening of the psychopathic hospital in 1920, about three hundred patients a year have been cared for in its wards and an increasing number, coming from every part of the state, have been examined in its out-patient department. It has been obvious, however, from the beginning that because of the great distances within the state and the delays of travel in some directions, a much greater service could be rendered if an extension of the out-patient department could be arranged that would permit the offering of such consultations nearer the sources of the problems. The possibility of developing a visiting psychiatric-clinic service with headquarters at the psychopathic hospital has been under consideration for some time, and in 1924 the demand was formulated so earnestly at the Iowa State Conference of Social Work that the director of the psychopathic hospital offered the services of members of his staff to hold such a visiting clinic as an experiment in some county that would bear the expense of transportation and maintenance. Requests for this experimental clinic were received from several communities, and these were studied from the standpoint of their social organization and of their general interest in mental hygiene, to determine which offered the most promise of intelligent and sustained coöperation.

A county in the west central part of the state, with a population of 16,400, was finally chosen for the experiment. Its

largest town contained 3,400 inhabitants. The secretary of the Social Service League, who also served as overseer of the poor, had interested her case committee, the county medical association, the public-health nurse, the county attorney, and the county and city superintendents of schools in the proposed clinic. Certain socially minded individuals in the community offered to lodge the clinic staff in their homes, and the county supervisors agreed to defray the traveling expenses and to provide meals. Several rooms in the county courthouse were assigned as clinic headquarters. A special committee was organized to take charge of the local arrangements and volunteers were secured to help with the clinic management and transportation about the county. A group of workers from the psychopathic hospital, including the director, the chief social worker, the psychologist, a student assistant in psychology, and one in social work, volunteered their services for a period of two weeks, and the experimental mobile clinic began work in Greene County in January, 1925, with headquarters at Jefferson, Iowa.

Before the arrival of the clinic staff, blanks were sent to the Social Service League to be given to those who wished to refer cases for examination. These included an application slip on which a statement of the problem and the identification data were to be given, an outline for a brief social-psychiatric history, and a form for a school report from the teachers on cases referred by them. Over two hundred requests for examinations were received in this way and were reviewed by the social workers of the unit in consultation with the referring agency for the first selection of cases. The greatest number were school children and the psychologists began with this group, giving individual Stanford-Binet tests in the school buildings. At the same time the teachers were interviewed by the social workers for additional information concerning the personality, the school performance, and the home background, if known, of the child. These psychological and educational data were reviewed each evening by the staff and a further selection was made of cases in which a thorough social investigation and a psychiatric examination were indicated. After these investigations had been completed, summaries of the findings were again reviewed by the staff, a

diagnosis of the difficulty was made, and recommendations were outlined. These were discussed with the school superintendent and in some cases with the parents.

After school hours and on Saturdays, children from other parts of the county and adult patients were seen by appointment at the courthouse. Each of the cases referred by agencies other than the schools was studied from its medical, social, psychological, and psychiatric aspects and was likewise reviewed in staff conferences. Clinic examinations were conducted in the same manner in two of the smaller towns of the county, and the psychiatrist was taken by a local physician to visit one rural family in its own home. No treatment was undertaken by the clinic in the community, but several cases were referred to the psychopathic hospital for further study and care. Permanent case records were made from the field notes later at Iowa City and written reports were sent back on each case. The secretary of the Social Service League greatly facilitated the work of the clinic by making many of the first contacts with patients and coöperating agencies, and in a number of cases undertook the responsibility for seeing that recommendations were carried out.

Interest in the clinic spread rapidly through the community and the members of the staff were called upon to speak before several groups such as the Parent-Teacher Association, the Rotary and the Lions clubs, the Social Service case committee, and groups of teachers. A large public meeting was arranged by the Women's Club at which the director discussed mental hygiene and the function of the clinic. The interest aroused by the clinic continued for some time after its departure and the principal referring agencies expressed themselves as satisfied that the project had been of considerable value to the community.

In all, 173 patients were examined. They were referred by four chief agencies—(1) the schools, (2) the Social Service League, (3) the courts, and (4) the physicians and the public-health nurse—and a small number were examined upon the direct request of relatives or of the patient himself. The clinic cases will be grouped for discussion in this report according to these sources. Almost every case presented problems in all three fields of study—the social, the psychological, and

the psychiatric—and the general nature of the material seen in the clinic may be shown by an analysis of the data in each of these fields.

The psychiatric problems presented by the 173 cases are indicated in the following table of diagnoses, classified according to the source from which they were referred:

Psychiatric diagnosis	*Total*	*Social Service*				
		School	*League*	*Courts*	*Doctors*	*Others*
Hypophrenia						
Dull-normal intelligence	34	25	7	1	1	0
Border-line intelligence	16	14	2	0	0	0
Moron intelligence ...	18	12	3	1	2	0
Imbecile intelligence .	3	1	1	0	1	0
Special reading disability	15	15	0	0	0	0
Chronic alcoholism	1	0	0	1	0	0
Paresis.	1	0	1	0	0	0
Senile dementia	1	0	0	0	1	0
Dementia praecox (tentative).	3	1	2	0	0	0
Paranoid conditions	2	0	2	0	0	0
Toxic-exhaustive psychosis	1	0	0	1	0	0
Epilepsy.	3	2	0	0	1	0
Psychoneurosis (tentative)	2	0	1	0	0	1
Organic nervous disease.	2	1	0	0	0	1
No psychiatric deviation	66	54	6	1	0	5
Undetermined.	5	3	0	0	2	0
Total.	173	128	25	5	8	7

The problems presented by the group psychologically are suggested by the following table, which shows the range and distribution of intelligence quotients as determined by the Stanford-Binet examinations, grouped according to Terman's classification:

Intelligence rating	*Total*	*School*	*Social Service League*	*Courts*	*Doctors*	*Others*
I.Q. 120–144 (very superior).....	9	8	0	0	0	1
I.Q. 110–119 (superior)	12	9	1	0	0	2
I.Q. 90–109 (average)	61	50	5	2	1	3
I.Q. 80– 89 (dull normal)	36	26	8	1	1	0
I.Q. 70– 79 (border line)	20	18	2	0	0	0
I.Q. 50– 69 (moron)	20	13	4	1	2	0
I.Q. 34– 49 (imbecile)	3	1	1	0	1	0
Undetermined.....	12	3	4	1	3	1
	173	128	25	5	8	7

The general nature of the social problems presented in the material seen in the clinic may be indicated by a classification of the cases according to the scheme proposed by Dr. Southard in *The Kingdom of Evils,*[1] in which he suggested Disease, Ignorance, Bad Habits, Legal Entanglements, and Resourcelessness as the five main divisions in the field of social maladjustment. The social investigations made in connection with the experimental clinic were not complete enough for an adequate social analysis in each case, but an attempt was made to determine the outstanding social problems as accurately as possible. The classification was as follows:

A. Disease	
1. Mental or nervous disease problem	1
With educational problem	4
With legal problem	3
With environmental problem	4
With educational and conduct problem	1
With conduct and environmental problem	1
8. Mental defect or special disability	1
With educational problem	45
With educational and physical problem	2
With educational and conduct problem	6
With conduct and environmental problem	3
With legal and environmental problem	1
With physical and environmental problem	1
With educational, conduct, and environmental problem	6
With educational, environmental, and mental disease problem	1
With educational, conduct, environmental, and mental disease problem	1
With educational and environmental problem	17
3. Physical disease or defect	1
With educational problem	2
With mental defect and environmental problem	1
B. Ignorance	
Educational problem	20
With conduct problem	12
C. Bad habits	
Conduct problems	12
With environmental problems	14

[1] *The Kingdom of Evils; Psychiatric Social Work Presented in One Hundred Case Histories, Together with a Classification of Social Divisions of Evil,* by E. E. Southard, M.D., and Mary C. Jarrett. New York: The Macmillan Company, 1922.

D. Legal entanglements	
With environmental problem	1
E. Resourcelessness	
Environmental problems	4
No social problem	8
Total	173

SCHOOL CASES

One hundred and twenty-eight, or almost three-fourths, of the cases examined in the clinic were referred by the town, district, or consolidated schools. They ranged in age from five to twenty-two years and included 82 boys and 46 girls. The distribution according to grades was as follows:

Kindergarten	3	Seventh grade	14
First grade	17	Eighth grade	15
Second grade	6	Ninth grade	9
Third grade	13	Tenth grade	5
Fourth grade	12	Eleventh grade	4
Fifth grade	12	Twelfth grade	7
Sixth grade	11		
			128

In order to avoid giving the impression that the clinic was interested primarily in the subnormal child and that reference to the clinic, therefore, implied some degree of mental defect, some of the brightest children in each school were selected by the teachers for examination. The teachers were also asked to refer children who were failing in their school work and those whose problem was one of behavior rather than of academic achievement. Of the children examined, 14, or 10 per cent, were referred by their teachers as "bright"; 84, or 65 per cent, as "dull, backward, or retarded"; and 30, or 25 per cent, as "nervous, peculiar, or unruly". Each child was given a Stanford-Binet test, and the distribution of the intelligence quotients in each of these three groups is shown in the table on page 765.

Over half of the children referred by the schools were of average or superior intelligence, about one-third were in the dull-normal and border-line groups, and one-tenth were found to be definitely feebleminded.

Intelligence ratings		*Total*	*Bright*	*Back-ward*	*Conduct problems*
Normal	I.Q. 120 or over (very superior)	8	6	1	1
(52 per cent)	I.Q. 110 to 119 (superior).	9	7	0	2
	I.Q. 90 to 109 (average)	50	1	31	18
Marginal	I.Q. 80 to 89 (dull normal).....	26	0	19	7
(35 per cent)	I.Q. 70 to 79 (border line).....	18	0	17	1
Defective	I.Q. 50 to 69 (moron)	13	0	12	1
(10 per cent)	I.Q. 25 to 49 (imbecile)	1	0	1	0
Not determined (3 per cent).....		3	0	3	0
Total.....		128	14	84	30

Bright Children.—The 14 children reported by their teachers as "bright" included eight boys and six girls, from five to eighteen years of age, in various grades from the kindergarten to the twelfth. All were doing good school work and their intelligence quotients were found to range from 106 to 143. In relation to their chronological age, eight were in the expected grade, three were somewhat behind, and three—all girls—were in the grade ahead. Considering their placement from the point of view of their mental ages, four were one grade below their indicated capacity; three two grades below; one three grades below; three four grades below; and two five grades below. Recommendations as to promotion, however, were made in accordance with the physiological and social maturity of the individual child rather than according to his mental age alone.

One of the cases in this group was that of a first-grade girl of very superior intelligence (I.Q. 141) who was the only child in a family of adults. She has acquired a very grown-up manner and could get along much more easily with older people than with other children. The examiner felt that, in her case, training in making social adjustments was very important and could be carried out better in a group of children of her own age than by allowing her to be advanced into the older group where she belonged intellectually. On the other hand, a well-developed five-year-old kindergarten boy was seen who was the leader in his class and volunteered the information that he was the smartest boy in his room. His

mental age was found to be only about a year in advance of his chronological age, but because of his attitude of superiority, it was felt that promotion into the first grade, where he would have more competition, might be a wholesome measure at this time. The eight superior children who were in the intermediate grades—the fifth to the eighth—were carrying their school work easily and presented no particular behavior problems. They are a group, however, that should have especial consideration in the school because of their potentialities for leadership. Endowed with superior native ability, it is important that they be trained to make full use of their talents, that they be given a broad cultural background, and that they early learn to recognize social values and to make good social adjustments. If their superior capacity is not recognized, they are apt to form habits of poor application and of inaccuracy. Double promotion may serve as a stimulus to some, but often entails physical and social demands beyond the maturity of the child and may result in the omission of important school work. The problem is being met in some schools by increasing the scope and requirements of the work in the intermediate grades for such children and this suggestion was made in a number of these cases examined in the clinic.

The four superior high-school pupils who were seen were already carrying full schedules and many non-academic activities, and were chiefly concerned with the question of whether or not to plan to go to college. The clinic findings in each case indicated the practicability of further academic training, and as a result, one of the senior girls who had expected to go to work after graduation was offered financial assistance by a generous member of the community so that she might attend the state normal school the next fall.

The children referred by the schools as "very bright" are listed in the order of their intelligence quotients in the table on page 767. The chronological age is given in years and months.

Dull, Backward, and Retarded Children.—The 84 children who were referred by their teachers because of difficulty with their school work proved to be an heterogenous group. Ac-

Sex	Chronological age	Grade	Mental age	I.Q.	Grade	Recommendations
M	11– 2	VI	16– 0	143	Very superior..	Promotion or increased work in present grade.
F	6– 6	I	8– 2	141	Very superior..	Social contacts with children.
M	12– 0	VI	16– 9	140	Very superior..	Promotion or increased work in present grade.
M	14– 0	IX	18– 0	125	Very superior..	College. Increased work in present grade.
M	14– 2	VIII	17– 8	125	Very superior..	College. Increased work in present grade.
F	13– 1	VIII	17– 1	123	Very superior..	College. Increased work in present grade.
F	18–11	XII	19– 0	119	Superior	College work.
F	15– 4	XI	18– 1	118	Superior	College work.
M	10– 5	V	13– 2	118	Superior	College work. Increased work in present grade.
M	5–10	Kindergarten 6–10		117	Superior	Promotion.
F	16	XII	18– 3	114	Superior	College work.
F	11–10	VII	13– 7	114	Superior	College work.
M	11–10½	VI	13– 7	114	Superior	Double promotion or increased work in present grade.
M	12– 7	VII	13– 4	106	Average.....	Some advanced academic work.

cording to the psychological examinations, one was of superior intelligence, 31 were of average intelligence, 19 were of dull-normal intelligence, 17 were of border-line defective intelligence, 12 fell in the moron group, one was an imbecile, and in three cases the intelligence quotient was not determined. It is obvious that factors other than intellectual equipment were operative in the difficulties of the first two sub-groups and these factors also appeared in some of the groups with the lower psychological ratings.

The 32 children referred as "dull" who were found to be of average or superior intelligence (I.Q. 90 and above) consisted of 22 boys and 10 girls. In a few cases—such as those of three children who were in a grade too far advanced for their intellectual capacity—the explanation of the difficulty seemed fairly simple. In others the failure seemed to be due to insufficient effort because of lack of interest in school work, but the underlying reasons for this attitude of indifference were often difficult to determine. Sometimes the trouble appeared to arise from the reactions of the child to the per-

sonality of one particular teacher. In several cases, emotional factors, such as extreme shyness, timidity, embarrassment when reciting, or a feeling of inferiority, apparently played a large part in the picture. One seventh-grade pupil who was considered "stupid" reported that she felt scared in the schoolroom and that her mother had been just like her and could always do better on written tests. When called upon to recite, she said that she sometimes could not think of anything. "Words don't come right when I'm scared. I often think of things afterwards I couldn't remember when the teacher called on me."

Some of the children who had lost interest in school work were also becoming conduct problems, and here environmental factors and improper home discipline were often found to enter in. One such case strongly suggested, in addition, the beginning of a true mental disease. This was a high-school boy who was reported as having a very poor attitude toward school and who was making no effort to learn. The summer before, he had gone West with another boy in a stolen car and now he was failing in all of his school work. He was permitted to carry only one subject, manual training, but was expected to remain in school all day. His mother blamed the school for all of his difficulties and gave the impression of being a peculiar person herself. The boy made a high average score on the intelligence test, but seemed inaccessible and showed a number of striking mannerisms and decidedly queer reactions which suggested an early schizophrenia.

Other children showed selective limitations in certain fields which indicated the need of special training. One eleven-year-old girl in the fourth grade was referred by the school at her mother's request because she was failing in her spelling and was considered subnormal by her teacher. She had recently been transferred from a Texas school where she had led her class in spelling. Investigation showed, however, that there her recitations in spelling had been entirely oral, whereas here all of the work was written. She was distinctly up to the average in her general intelligence and was eager to begin work upon written spelling drills at home when the situation was explained to her. The next day she reported that her father had given up his noon hour to go over her written

lesson with her, and it was felt that with such interest on the part of the child and with the coöperation of her parents, she would soon be able to overcome her handicap.

Fourteen children in the group referred as "dull" were found to have had special difficulty in learning to read and formed a sub-group of particular interest. They were from seven to seventeen years of age and were scattered through the first nine grades of school. Thirteen were boys. Their disabilities in reading varied from a tendency to the reversal of letters and syllables and an insecurity in recognizing words —fairly common among all young children—to a practically complete failure to read any words correctly. Because of their special difficulty, they were unable to keep up in the other studies that called for reading, were retarded in school, and were usually considered inferior in intelligence by their teachers. These children showed a variable emotional reaction to their failures and some had developed a decided feeling of inferiority. In spite of their handicap, ten made at least an average score on the Stanford-Binet examination, but supplementary tests indicated that this method of measuring intelligence probably does not give an adequate estimate of the general intellectual capacity of such children. The number of these cases and the psychiatric and educational problems involved aroused a very special interest on the part of the clinic staff in such difficulties, and one of the children was later studied intensively at the psychopathic hospital by the director, with the result that certain problems in cerebral dominance were brought to light which are to be made the object of further scientific investigation under a special research program during the coming two years.[1]

The children referred as "dull" who were found to be of average or superior intelligence are listed in the table on page 770. The starred cases in this and the following tables were also referred as conduct problems.

In addition to the 32 children of average intellectual ability the group which was referred because of difficulty with school work included 19 who were found to be of "dull-normal" intel-

[1] A preliminary report on these cases has been published: "Word-Blindness in School Children", by Samuel T. Orton, M.D. *Archives of Neurology and Psychiatry*, Vol. 14, pp. 581–615, November, 1925.

Sex	Chronological age	Grade	Mental age	I.Q.	Special factors
M	7– 7	II	9– 3(?)	122(?)	Special reading disability.
M*	15– 5	VIII	16– 3	109	Probable dementia praecox.
F	11– 0	IV	11–10	108	Written spelling difficulty.
M*	18– 0	X	17– 0	106	Increased work. Guidance by De Molay.
M	9– 2	III	9– 8	105(?)	Special reading disability.
M	6– 2	I	6– 6	105	Needs encouragement. Training for lisp.
M	7– 5	I	7– 8	103(?)	Special reading disability.
M	10– 5	III	10– 7	102(?)	Special reading disability.
M	16– 0	IX	16– 2	101	Interest factor.
M	14–10	VIII	15– 0	101	Interest factor.
M	11– 6	VII	11– 8	101	Repetition of grade advised.
M	18–11	XI	15–10	99	Sympathetic encouragement. Feeling of inferiority.
F*	13– 0	VIII	12–11	99	Encouragement.
M*	10– 1	V	10– 0	99	Interest. Home discipline.
M	9– 6	III	9– 5	99	(?)
M	8–11	III	8–10	99(?)	Special reading disability
M	9– 3	III	8–11	96(?)	Special reading disability.
F	10– 7	IV	10– 1	95	Needs special assistance. Social problem.
F	8– 5	II	8– 0	95	Environmental problem.
M	17– 0	XI	15– 1	94	Special help needed.
F	14– 2	VII	13– 3	94	Emotional blocking in oral work.
F*	13–11	VIII	13– 1	94	Environmental problem.
F	13–10	VII	13– 1	94	Interest factor.
F	16– 1	IX	14– 9	92	Timid. Needs sympathetic encouragement.
M*	14–10	VII	13– 8	92	Needs special encouragement and motivation.
M	8– 9	II	8– 1	92(?)	Special reading disability.
M	9– 4	II	8– 8	91(?)	Special reading disability.
F	9– 4	III	8– 6	91(?)	Special reading disability.
M	6–11	I	6– 4	91	(?)
M*	15– 8	VIII	14– 2	90	Environmental problem.
F	14– 8	IX	13– 3	90	Special help needed.
M	7– 1	I	6– 5	90	Needs sympathetic encouragement.

ligence (I.Q. 80–89). The problems of this group seemed to resolve into the need for special assistance and extra time to complete the work of the lower grades and for vocational training of a very practical type for the older boys and girls. In some of the schools such courses were offered only to the upper classes in which advanced work in academic subjects

was also required, so that this training was not available to the children who perhaps needed it most. One fourteen-year-old girl with an intelligence quotient of 85 who was in the eighth grade wanted to drop school because she did not like it. She did well at housework at home and thought she might like domestic science, but "didn't like the sound of Latin and algebra", which she would have to take with it. All of her school work was poor, she had lost interest in it, and was becoming a conduct problem in the community as well as in the classroom.

The achievement possible for the duller children, with perseverance and encouragement, was shown in the case of a twenty-two-year-old girl with an intelligence quotient of 80. Although very sensitive over her slow progress, she had persisted in school, working her way through, until she had reached the twelfth grade and was about to graduate from the commercial course. Her employers reported that she was very efficient at housework and it seemed probable that she would make a good social and economic adjustment after leaving school. A summary of these cases follows:

Sex	*Chronological age*	*Grade*	*Mental age*	*I.Q.*	*Recommendations*
F	18– 0	XII	14– 3	89	Special help. Not college.
F	8– 9	I	7– 8	88	Special assistance.
M	5– 1	Kindergarten	4– 6	88	Eye examination.
M	18– 0	XI	13–11	87	Farm training. Stop school.
M	16– 0	IX	13–11	87	Practical training.
M	14– 0	VIII	12– 3	87	Sympathetic encouragement.
M	10– 7	IV	9– 2	87	Special assistance.
F	7– 6	I	6– 6	87	Special assistance.
F	16– 0	IX	13– 9	86	Special assistance.
M	16– 0	IX	13– 7(?)	85(?)	Special reading disability.
F*	14– 0	VIII	12– 0	85	Domestic science.
M	12– 9	VI	10– 9	84	Special assistance.
M	7–11	I	6– 8	84	Extra time to complete grade.
M	11– 8	IV	9– 8	83	Special assistance.
F	11– 1	IV	9– 3	83	Special help in reading.
M	17– 0	VIII	14– 2	82	Practical training.
F	6– 8½	I	5– 6	82	Special assistance.
F	22– 0	XII	12– 9	80	Summer work.
F	13– 2	VII	10– 7	80	Practical training.

The need for special assistance in academic work and of greater opportunity for manual training of various kinds was even more striking in the 17 children classified as "border-

line defectives'' (I.Q.'s 70 to 79). They were considerably retarded in their school placement and were of the type whose educational problem is being solved in some schools by the special or ungraded room where the curriculum can be adapted to their needs.

The children in this group are listed in the following table:

Sex	*Chronological age*	*Grade*	*Mental age*	*I.Q.*	*Recommendations*
M	11–11	IV	9– 5	79	Help and training.
M	17– 0	X	12– 5	78	Farm work.
F	14– 6	VI	11– 4	78	Practical training.
M	16– 0	VIII	12– 4	77	Practical training at once.
M	18– 0	XII	12– 3	77	Work after graduation from high school.
M	12– 2	V	9– 5	77	Help and training.
M*	17– 0	VIII	12– 2	76	Manual or farm work. Supervision.
F	12– 0	IV	9– 1	76	Special help.
M	10– 3	III	7– 8	75(?)	Special reading disability.
F	10–10	IV	8– 0	74	Demotion(?) Supervision.
M	13– 5	V	9–11	74	Special help.
M	17– 0	IX	11– 8	73	Special training for printer.
M	17– 0	VIII	11–10	72(?)	Special reading disability.
M	17– 0	IX	11– 6	72	Redirection of attitude.
M	16– 2	VII	11– 4	71(?)	Special reading disability.
M	17– 0	X	11– 3	70	Vocational training.
M	14– 2	VII	9–10	70(?)	Special reading disability.

Twelve children were found to belong in the ''moron'' group (I.Q.'s 50 to 69) and one had the rating of an imbecile (I.Q. 49). They were quite unable to keep up with the regular school work, but might have profited to some extent by instruction of the ungraded-room type with emphasis upon hand work and habit training. Four were already social problems and indicated the special need of this group for adequate social supervision and behavior training. Institutional care was advised for the two children with the lowest ratings, as they came from homes very deficient in resources for such training.

The children in the moron and imbecile group are listed in the table on page 773.

Intelligence quotients could not be obtained in the cases of three young children, one who did not talk and two whose birth dates were unobtainable.

The one who did not talk, a boy, aged five years and ten months, presented a problem of home discipline. He was in

Sex	Chronological age	Grade	Mental age	I.Q.	Special factors
M	12–10	V	8–10	69	Also a social problem.
F	8–11	I	6– 2	69	Also a social problem.
M	14–10	VI	10– 1	68	
M	10– 7	III	7– 2	68	
M	16–11	VIII	10– 8	67	
F	14– 5	VII	9– 7	67	Peculiar. Social problem.
F	14– 1	VII	9– 5	67	Tonsils and adenoids.
F	14–11	VI	9– 7	65	Social problem.
M	14– 1	V	9– 3	65	
M	11– 6	III	7– 6	65	
M	15– 4(?)	VII	9– 4	61(?)	
F	11– 0	II	6– 2	56	Institutional care advised.
F	14– 1	III	7– 0	49	Institutional care advised.

the kindergarten. The other two, both girls about seven years old, were in the first grade. The mental age of one was 6 years, 4 months, and of the other 6 or 7 years. No special factors were noted in the case of the first, but the second was recorded as in need of sympathetic encouragement at school and additional home training.

Nervous, Peculiar, and Unruly Children.—The 30 children referred to the clinic by the school because of "nervousness" and deviations in the field of conduct, rather than failure in academic work, presented a number of different pictures and offered material for much more intensive study than was possible in the clinic's survey. The group included twice as many boys as girls, and many of the same factors that were encountered in the problems of the children of average intelligence who were referred by their teachers as "dull" appeared also in these cases. Several who had good intellectual ability were distinctly bored with school, and showed mild conduct disorders in the classroom, perhaps because they did not have enough to do. In the case of one ten-year-old boy with an intelligence quotient of 119, promotion into the next grade was recommended to see whether more difficult work might not absorb his excess energy. Seven were found to be of "dull-normal" capacity and this, particularly when coupled with a poor home environment, seemed to account in a large measure for their lack of interest in school. Some were of the emotionally unstable type who need patient and sympathetic

encouragement. One of these was an eight-year-old boy who had repeated the first grade and was said "to go to pieces when he tried to do anything". He was considered by his teacher to be subnormal in intelligence as well as extremely nervous. He was found to be of average intelligence, but showed evidences of a special disability in reading. His parents, moreover, were said to be in the habit of shouting when correcting him, and the boy reported that he felt "nervous" when called upon to recite, just as he did when his father corrected him at home.

Ten of the children in this group were referred because of problems of school discipline, and here again the investigation pointed in almost every instance to contributing factors in the home situation. One such case was a fifteen-year-old boy in high school who had just been readmitted to school after suspension and was said to be sulky and defiant. He talked freely with the psychiatrist and indicated that for some time past he had felt himself treated unfairly by his family, who expected him to come up to the school standards set by his very bright older brother and sister and were inconsistent in their demands as to his behavior at home. His parents frequently argued in his presence over what should be required of him, and he had learned that in spite of his father's strictness, he usually could get the concessions that he wanted from his mother. At last he had broken away from the situation by taking his father's car and leaving home. He was apprehended and returned and made restitution out of his savings. When seen by the clinic, he was still somewhat in doubt as to whether he "had the brains" to make good in school and was confused as to what were fair requirements for his behavior at home. He asked the examiner, for example, how many nights a week a boy should be allowed to stay out. He would like from three to five, his father would allow none, and his mother might compromise on two.

In contrast to these cases of conduct deviations in which mental attitudes seemed of prime importance, three of the "nervous" children presented symptoms of true nervous disease—two of epilepsy and one of probable multiple sclerosis—and were referred to their own physicians or to the psychopathic hospital for further observation and care. Another

case, referred for persistent masturbation, indicated the need of specific habit training at home.

The intelligence quotients and other data for this group are summarized in the following table:

Sex	Chronological age	Grade	Mental age	I.Q.	Group	Recommendations
M	9– 2	IV	11– 0	120	Very superior	Habit training.
M	10– 6	V	12– 6	119	Superior	Needs incentive.
M	10– 2	IV	11– 7	113	Superior	Speech defect.
M	12– 4	VI	13– 2	107	Average	Unstable. Poor home.
M	6– 6	I	7– 0	107	Average	Home problem.
F	11– 9	VI	12– 6	106	Average	Easily embarrassed.
F	15– 4	X	16– 7	104	Average	Epilepsy(?)
M	15– 6	X	15–10	102	Average	Poor home discipline.
F	10– 2	V	10– 5	102	Average	Home problem.
M	8– 4	III	8– 6	102(?)	Average	Special reading disability. Emotional blocking.
M	13–10	VIII	13–10	100	Average	Epilepsy.
M	10– 2	IV	10– 3	100	Average	Interest and effort.
M	18– 0	XII	15– 5	99	Average	
M	16– 0	XII	15– 8	98	Average	Needs social training by group.
M	9– 0	III	8– 6	94	Average	Interest and effort factor.
F	15– 4	VII	14– 4	93	Average	Home problem.
F	10– 5	V	9– 8	93	Average	Interest factor.
M	13–10	VII	12–11	92	Average	
M	6– 5	I	6– 0	92	Average	Discipline problem.
F	11– 6	IV	10– 6	91	Average	Poor home.
F	6–11	I	6– 4	91	Average	Poor home.
F	8– 9	II	7–10	89	Dull normal	
F	9– 7	I	8– 6	88	Dull normal	Intellectual problem. Poor home.
M	6– 5	I	5– 8	88	Dull normal	Intellectual problem. Poor home.
M	15– ?	VI	12– 9	85(?)	Dull normal	Home discipline.
M	9– 0	III	7– 8	85	Dull normal	Intellectual problem. Poor home.
M	12– 7	V	10– 6	83	Dull normal	Manual training.
M	12– 0	V	9– 9	81	Dull normal	Interest and effort factor.
F	14– 3	VI	10– 4	72	Border line	Intellectual problem. Poor home.
M	11– 2	V	6– 4	56(?)		Nervous-system disease.

SOCIAL SERVICE LEAGUE CASES

Twenty-five cases were referred to the clinic directly by the Social Service League, which was also interested in 46 of the cases referred from other sources, making a total of 71 in

which there was a recognized social problem. In addition, several cases, upon analysis, presented serious environmental difficulties which had not previously come to the attention of the referring agency, so that, in all, probably one-half of the total number of cases examined in the clinic presented a social as well as a psychiatric problem. The Social Service League cases included individuals known to the league because of their failure to make an adequate social adjustment, as indicated by unemployment and domestic difficulties; children from these families, for whom intelligent social guidance was needed to prevent similar failures in adult life; and cases of suspected mental defect or disease in which medical advice was necessary to determine proper care.

Five unemployment problems were referred, in each of which a consideration of the mental and personality factors proved of importance. The first was an unmarried man of forty, who was out of work much of the time. He seemed to have a good personality, but was limited in intelligence and was also handicapped by remediable physical defects. The problem appeared to be one of providing medical treatment for his physical condition and then giving him assistance in locating work that he was capable of doing.

Another man came frequently to the Social Service League for financial assistance for his family because of unemployment. He was a good workman, but had given up a number of jobs because he felt that his various employers "had it in for him". The psychiatric examination brought to light a distinct paranoid trend, but no evidence of progressive deterioration. The man had considerable insight and it seemed probable that he might with guidance be able to make an adjustment in the community if an employer could be found who would make allowance for his peculiarities.

Two older boys of dependent families were seen who had stopped school, but had not yet found satisfactory occupation. One made a "high-average" score on the tests and the other a "dull-normal" one and advice was given for vocational training consistent with their interests and their intellectual abilities.

Another vocational problem concerned a young widow who was receiving a mother's pension. The Social Service League

was considering giving her an opportunity for stenographic training in order that she might become self-supporting. Her mental rating, however, cast some doubt upon the advisability of this type of training.

The rôle that mental factors may play in domestic problems was suggested in several cases referred by the social agency. A young married couple were examined who were having continual trouble. The husband failed to provide adequately for his family and had deserted them several times. He was found to have very defective intelligence and probably saw no better way to meet his difficulties than by such escape. His failure to support the family seemed due to his inability to find work of the simple manual type to which his capacity was limited. His wife, although normal in intelligence, was a person of poor social standards and little sense of responsibility. Their little girl was also subnormal and showed the effects of her poor home training.

The mother of another well-known "problem family" was referred because of her constant demands for charitable assistance. The examination showed that she was of dull-normal intelligence, but had acquired a mental attitude that was the real obstacle to any constructive social treatment. Its basis seemed to lie in her own social experience. She gave a history of a childhood home of unusually low standards, of an early marriage, of many economic difficulties aggravated by sickness, of frequent pregnancies, and of increasing discouragement. During the influenza epidemic, the family was obliged to seek outside assistance, which unfortunately was continued by charitably minded individuals until it came to be considered a matter of just due. After the organization of the Social Service League and its attempts at budgeting and supervision, she became exceedingly antagonistic, her husband felt "insulted", and their coöperation could not be gained. The children reflected the same attitudes, were insolent in school, and begged upon the street. The success of the social worker with such a problem would depend largely upon her understanding of the genesis of the mental attitudes involved and her skill in combating them.

Another referred case was that of an eighteen-year-old girl who had attempted to commit suicide. After the death of her

mother, the father had proved quite inadequate to keep the home together. She was attempting the supervision of an active younger brother and had frequent clashes with her father over questions of his discipline. Upon examination, the father gave an intellectual rating of 81 and displayed a marked lack of insight into the situation and considerable indifference toward it. The daughter, on the other hand, was not only much brighter (I.Q. 101), but had high ambitions for the family which were repeatedly blocked because of her father's limitations and attitude.

The Social Service League referred eight children from four problem families. Two were backward in school, three were considered nervous or peculiar, and for three no problem was stated. The school difficulties in each instance proved explainable by the intelligence ratings. The behavior of two brothers, eight and five years of age, on the other hand, illustrated the possible effects upon children of a disorganized family life. Both were reported as "excessively nervous" at home, and the younger had had occasional attacks resembling convulsions. The medical examinations were negative; the intelligence quotients—114 and 88—indicated no particular handicap in the intellectual field. The social investigation, however, showed that the father was dead, and the mother, suffering from tuberculosis, was quite unable to cope with two lively boys. The situation was complicated by the presence in the home of an epileptic grandmother, and these environmental factors had apparently directly conditioned the "nervousness" of the little boys.

The Social Service League also acted as the referring agency for seven cases in which there was a question of mental defect or of mental or nervous disease. These had come to its attention either because of the social problem involved or because of requests for assistance in securing necessary papers for such examinations in Iowa City. One man, referred also by his own physician, had been a problem to the community ever since he had been in a slight accident while in a training camp during the war. He had many somatic complaints for which no physical basis was found, felt that every one—and particularly his wife—was against him, and expected the county to support him. He was generally con-

sidered feebleminded. The mental examination, however, showed that he was not markedly defective in intelligence, but had acquired mental reactions suggesting a paranoid type of dementia praecox and was probably deteriorated. His immediate financial difficulties were relieved by compensation from the War Department, but it was felt that a guardian should be appointed for him and that unless his conduct could be closely supervised, he might become a menace to the community.

The possibility of a mental disease was recognized in the case of a man referred to the clinic whose family had been known for some time to the social agency because he had never supported them well. For the past three years, following a stroke, he had become increasingly irritable and had not only ceased to work, but was constantly threatening his family and the town officials. His relatives were anxious for an examination and the local physician asked for consultation from the clinic psychiatrist. The examination showed evidence of syphilis of the central nervous system, and the man was sent to the psychopathic hospital for further laboratory tests. The diagnosis of paresis was confirmed, and he was later committed to a state hospital. Wassermann tests were made on the children and they were referred to their family physician for further observation and treatment if it proved necessary.

Another case of mental disease was suspected in a situation involving a woman of sixty-seven who was bringing up her fourteen-year-old granddaughter. The child had been referred to the clinic by the school and was found to be feebleminded. This woman was recognized as peculiar and had been causing more or less trouble in the community by her litigiousness. She accused her neighbors of stealing her potatoes and her landlady of conducting a house of ill fame, and was constantly threatening law suits against prominent citizens of the town. The examination showed that her conduct was governed by systematized delusions and she was considered a potentially dangerous person, probably committable, and certainly not a fit guardian for a young girl.

The peculiar behavior of a girl of twenty-three who showed a tendency to withdraw from companions of her own age and

was becoming very seclusive led to her being referred to the clinic. The examination showed a schizoid personality and possibly an early schizophrenia, and attempts at social stimulation were recommended, with a period of observation later at a mental hospital if her condition did not improve.

The question of institutionalization of adults who are recognized as feebleminded, but are law-abiding and are not a charge upon the community, is often raised, and two such cases were referred to the clinic for advice. One was found to have a severe defect in intelligence, but was doing useful work at home on the farm, where he was carefully supervised by his parents, who understood his limitations. As long as they were able to provide for him, there seemed to be no need for institutional care. The other was a well-meaning girl of nineteen who was of considerable help to her widowed mother, a laundress. The home was a poor one, however, with no opportunities for further training or for wholesome recreation. The girl was showing a normal interest in the opposite sex, but would probably never be capable of managing a home or children of her own. From the social point of view, therefore, work in an institution for the feebleminded—at least during her child-bearing years—seemed to offer the best means of adjusting her situation.

A summary of the cases referred by the Social Service League is shown on page 781.

COURT CASES

The district court was not in session during the clinic's visit and the county jail had but one inmate, who was promptly referred to the clinic by the county attorney. This man was under arrest for driving an automobile while intoxicated, but it had not been decided whether to try him on this charge or under the habitual-criminal act to which he was liable, as he had previously served two sentences at the state penitentiary for larceny. While in prison, he got along well and made good use of his rather superior mechanical ability. As soon as he was released, however, he would begin to drink and would get into some new difficulty in the community. The examination showed no evidence of mental disease or mental defect of a degree sufficient to account for his conduct dis-

	Sex	Age	Reason referred	I.Q.	Diagnosis	Recommendations
Employment problem	M	18	Out of school; no work. Mother semi-dependent	107	High average	Vocational training for skilled mechanical work.
	F	21	Mother's pension case	86	Dull normal	Vocational training.
	M	19	Out of school; no work. Mother semi-dependent	82	Dull normal	Vocational training for trade.
	M	40	Often unemployed	71	Border line. Hernia	Medical care. Simple work.
	M	30	Changes jobs often. Family dependent	..	Paranoid	Social supervision.
Domestic problem	F	18	Attempted suicide	101	Average	Social guidance.
	F	32	Domestic friction	90	Low average	
	F	33	Dependency	89	Dull normal	Attempt to change attitude.
	M	46	Unable to handle daughter	81	Dull normal	Assistance in handling children.
	M	40	Desertion and non-support	67	Moron	Supervision. Simple work.
Child-guidance problem	M	8	Nervous child	114	Superior	Change environment.
	M	7	Dependent family	100	Average	
	F	11	Dependent family	98	Average	
	F	8	Dependent family	89	Dull normal	Special assistance with school work.
	M	7	Will not attend school	89	Dull normal	Return to school with new teacher.
	M	5	Nervous child	88	Dull normal	Change environment.
	F	10	Slow in school	78	Border line	Social supervision.
	F	8	Peculiar	53	Moron (?)	
					Praecox reactions	Social supervision.
Problem of feeble-mindedness	F	19	Sex delinquency	65	Moron	Close supervision or institutional care.
	M	17	Institution (?)	32	Imbecile	Home supervision.
Question of mental disease	M	42	Peculiar conduct	80	Paranoid praecox	Supervision of parole type.
	F	23	Seclusive	63	Moron; praecox reaction	Companionship.
	M	43	Peculiar conduct	..	Paresis	Psychopathic hospital.
	F	57	Litigiousness	..	Paranoid psychosis	Institutional care.
	F	30	Physical complaints	..	Psychoneurosis (?)	Thorough physical examination.

orders, but suggested a mild deterioration from chronic alcoholism. It was felt that a recurrence of his delinquencies was to be anticipated and that he should be tried under the habitual-criminal act, under which he could be given a maximum sentence of twenty-five years, rather than for his present offense.

Another legal case concerned an illegitimately pregnant girl whose parents wished to bring court action. The county attorney requested her examination to determine whether she was capable of giving reliable testimony and what legal procedure would best protect her rights. The examination showed that she was definitely feebleminded and her parents were advised that home care and close supervision were indicated rather than the marriage they were considering for her. Four of her younger brothers and sisters were also examined and were found to have intelligence defects of varying degrees. The family had not previously been known to the social agency and these findings strongly suggested the need of outside supervision to prevent similar problems arising in the cases of the other children.

Two transients who were being detained for investigation, a man of thirty-five traveling with a girl of twelve whom he claimed was his sister, were also referred, and the clinic's report that he was of good average intelligence while the girl was subnormal, together with laboratory findings, proved of assistance to the authorities in working out a plan to handle the social and medical as well as the legal aspect of the situation.

Another type of court case seen in the clinic was a boy from a small town who had just been placed under arrest for stealing an automobile. He was referred by the sheriff because he persistently denied his guilt in the face of positive evidence and had attempted to commit suicide when arrested. The medical examination showed that he was very much confused, and instead of being kept in jail, he was sent at once to the psychopathic hospital at Iowa City. He had recently had pneumonia and pleurisy and presented symptoms suggestive of active tuberculosis. His mental condition was diagnosed as a toxic-infective-exhaustive psychosis, and after six weeks of hospital care he had improved sufficiently to be sent home

and the charges against him were dismissed. Had it not been possible to secure this psychiatric examination at the time of his arrest and to arrange at once for his transfer to a hospital, the outcome for the boy's physical and mental health might have been very serious.

A summary of these five medico-legal cases follows:

Sex	*Chronological age*	*Mental age*	*I.Q.*	*Diagnosis*	*Special factors*
M	35	16– 9	105	Psychopath(?)	Sex problem(?)
M	47	16– 3	102	Chronic alcoholism	Repeated delinquencies.
F	12	10– 0	81	Dull normal	Environmental problem.
M	19	11– 1(?)	69(?)	Toxic psychosis	Attempted theft and suicide Confusion.
F	18	9– 2	57	Moron	Illegitimately pregnant.

CASES REFERRED BY PHYSICIANS AND PUBLIC-HEALTH NURSE

Medical consultations were given on eight private cases referred by six local physicians and the public-health nurse. These cases included four subnormal children in whom the question of thyroid insufficiency was raised and two of whom were later given laboratory examinations at the psychopathic hospital. Mental retardation due to sensory deprivation was presented in the case of a little girl of six with a hearing defect for whom education at the state school for the deaf was recommended. Another six-year-old girl was seen who appeared to be of normal intelligence, but was backward in talking. Suggestions were given to the mother for training and arrangements were made for an examination a year later at the psychopathic hospital. More strictly medical problems were presented in the case of a man of seventy-one who showed evidences of senile dementia complicated by a recent encephalitis, and in that of a young girl with epilepsy whose physician wished advice as to luminal therapy. Recommendations for this were given after a period of observation and experiment at the psychopathic hospital.

The cases referred by the physicians and the public-health nurse are summarized on the following page.

Sex	Chronological age	Mental age	I.Q.	Diagnosis	Recommendations
F	17	15– 6	97	Epilpetic	Psychopathic hospital.
M	8	6–10	80	Recovering from chorea	Return to school. Diet and special training.
F	18	9– 7	60	Moron	Bureau of Mental Research at psychopathic hospital.
M	8	4–10	58	Moron	
M	10–2	4–10	48	Imbecile	Bureau of Mental Research at psychopathic hospital.
M	71			Senile dementia	Institutional care(?)
F	6	?	?	Retarded speech	Speech training by mother.
F	6	?	?	Hearing defect	State school for the deaf.

CASES REFERRED BY INDIVIDUALS

Seven cases were referred to the clinic directly by interested individuals. Two of these were children of school superintendents and one was a high-school girl who was having difficulty with her work and wanted advice as to whether college training was practicable for her. Another was a small boy who was being kept out of school because he had formerly had chorea. His parents had been told by a chiropractor that he would "become an idiot" if returned to school within a year and were relieved to receive a different prognosis from the clinic. Psychiatric consultation was also sought by an intelligent Jewish woman of forty who asked for an examination because she felt blue and uneasy and had had various peculiar sensations. Her marital relationship seemed satisfactory, but her husband's business had necessitated frequent moves, and because of her nationality, she had had difficulty in finding congenial friends in the small town in which she was now living. Naturally active and capable, she became discontented when she had nothing to do and had begun to think more and more about herself and to worry over her condition. She was relieved to have the psychiatrist tell her that her symptoms did not indicate the beginning of any serious mental disorder and was coöperative in working out a plan whereby her interests might be better absorbed by outside activities. A summary of these cases is shown on page 785.

CONCLUSION

The number of cases referred to the mobile clinic during its short stay in Greene County indicated the interest of the community in the experiment and its recognition of the impor-

Sex	Chronological age	Grade	Mental age	I.Q.	Group	Special factors
F	6- 2	I	7- 6	122	Very superior	No problem.
M	7-11	III	9- 4	118	Superior	Better hygiene and return to school recommended.
F	15- 8	X	17- 4	111	Superior	No problem.
F	10-10	V	11- 9	108	Average	No problem.
F	16- 0	XI	15- 3	95	Average	Vocational guidance.
F	17- 0	IX	15-10	93	Average	Conduct problem.
F	40	..	..	..	Psychoneurosis(?)	No outside interests.

tance of mental-hygiene problems. Although little preliminary educational work had been carried on and some parts of the county were not reached at all, it was evident that there was more than enough psychiatric material in such a community, which was readily accessible for examination, but which ordinarily would never find its way to a hospital, to warrant a visiting consultation service. The problems presented, moreover, proved to be complex, involving social and psychological as well as psychiatric factors in almost every case, and calling for study in each of these correlated fields. The advantages of a complete mental-hygiene unit, consisting of a psychiatrist, a psychologist, and a psychiatric social worker, for such examinations were again demonstrated. The opportunity of seeing the patient in his own community, where his customary environment and habitual reactions could be studied and where many informants were available, made possible a better understanding of the situation than is usually the case in a hospital out-patient examination. In those cases in which extensive laboratory testing or prolonged and intimate observation in a controlled environment was necessary, this need was met by sending the patient to the psychopathic hospital.

Because of its transient residence in the community the clinic was able only to initiate or suggest treatment to be carried out by other agencies and its service, therefore, was largely of a diagnostic and advisory nature. In many of the clinic cases, however, a clear-cut diagnostic statement of the problem proved sufficient to suggest to the referring agency the measures necessary to bring about an adjustment of the difficulty. In the court cases, the clinic limited its function specifically to the presentation of its findings, to be acted upon

in whatever way the prosecuting officers or jurists saw fit. In the school cases, an attempt was made to indicate the special educational needs of the indivdual child, but it was felt that in most of these cases the school could best determine how such recommendations should be carried out. Similarly, many of the problems referred by the Social Service League proved to be such as could be adequately handled by the organization after the nature of the difficulty was understood. The more strictly medical cases were referred to the local physicians and treatment at the state university hospital or the state psychopathic hospital was suggested for some. In cases where commitment to a state institution seemed advisable, the nature of the situation was outlined to the referring agency, which was left free to proceed or not with legal action through the usual channels.

Some cases of psychiatric deviations and of behavior disorders were encountered in which psychiatric-social treatment in the community was indicated, but in which local facilities for such treatment were quite inadequate. This is a difficulty inherent in the work of visiting psychiatric clinics in communities where there are neither physicians nor social workers with adequate psychiatric training, but as much guidance as possible was given to the existing local agencies in these particular cases. Follow-up consultations were offered through the out-patient and the social-service departments of the psychopathic hospital and a return visit of the clinic was promised if there was sufficient demand.

The experiment in Greene County indicated both the need and the feasibility of extending the out-patient service of the psychopathic hospital into the semi-rural districts of the state, and the cases of special disability in reading encountered there stimulated an intensive study of certain problems in cerebral physiology which promise to throw considerable light upon the genesis of this difficulty. Continuation of both the research program and the experiment with mobile mental-hygiene clinics by the psychopathic hospital has been made possible for a period of two years by a grant from the Rockefeller Foundation and aid from the Extension Division of the State University of Iowa. Both phases of this project were begun in January, 1926.

PUBLIC AND PRIVATE PROVISION FOR THE EPILEPTIC

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BEFORE we take up the history of colony care for epileptic patients both in this country and abroad, it may be well to note some of the factors that helped to bring it about.

The peculiarity of the epileptic make-up has been recognized throughout the ages. It has, moreover, been a common belief that this personality would change and the mental stigma of the disease disappear as soon as the seizure epoch subsided. In other words, the epileptic temperament was considered to be directly due to the occurrence of the seizures, and every effort at sedation was made. We know now that the personality antedates the seizure epoch, although it often exhibits itself in an exaggerated form after the onset of seizures.

It was also recognized that the disorder as such was very intractable, defying any and all means of remedy. Sooner or later, epileptic individuals who were low in the economic scale had to be considered as public charges and to be sent to various hospitals and institutions, or they drifted into almshouses. When an epileptic became temporarily insane, he was removed to a state hospital. The almshouse had no proper environmental treatment and the habits of epileptic patients consigned to it often deteriorated into the most vicious mental depravity and idleness. Even to-day only too many such patients are still in almshouses throughout the country. Epileptics sent to hospitals for the insane, when their temporary disorder is over, find themselves sharply restricted in liberty and in opportunity to keep up their normal interests. They react according to their innate nature, and the authorities are put to any amount of trouble in moving them about for the peace and comfort of all concerned. Next to almshouses, the asylums of this country harbor the greatest

number of the epileptic poor. The indigent epileptic population is to be found for the most part either quartered upon poor relatives or interned in institutions of these two types.

Experienced epileptologists realized at once that the vast majority of epileptics stood segregation of any sort poorly, particularly close grouping; they realized also that the need for proper classification made adequate provision expensive. In many states, very unwisely, the epileptic and the feebleminded have been interned in the same institution. This procedure is still in force in many states. Almost no public provision for the epileptic is better than that afforded by almshouses or asylums and institutions for the feebleminded. The demand for the internment of epileptics is for the most part due to the general realization that the epileptic at large is a misfit economically and socially, and that his make-up, even more than his occasional seizures, renders him incompetent to make normal adjustments to community life. This fact alone explains much of the *laissez faire* attitude of the general public, which seems to act upon the assumption that the problem of greatest importance is to secure its own safety and comfort first, by removing the epileptic from the community, instead of trying to equip institutions for the final social and economic reconstruction of epileptic patients. The insane often fare a little better than the epileptic, as not only do their mental disorders usually appear at a later period of life, but they are, perhaps, a greater public menace if their liberty is unrestricted. The feebleminded are the best provided for, since with them the possibility of cure is nil; only improvement is to be hoped for, and their internment is for the most part permanent. The epileptic is generally considered only a little less hopeless than the feebleminded. Where public provision has been made, however, it has often been most inadequate for the task in hand. Only by the closest coöperation on the part of all concerned can proper housing be provided. Knowing full well what a need there is for shops, schools, and above all proper institutional personnel, one can estimate the tragedy of interning epileptics on any parsimonious plan.

Doubtless there are many good and obvious reasons why more private colonies for epileptics have not been established

in the past. Aside from economic considerations, the very nature of the epileptic makes segregation and colonization difficult. His antisocial nature forbids an objectivated interest toward the home in which he is interned, however long he may reside in it. He never gets wonted to it nor does he revisit it or keep up his correspondence with the management or with his fellow associates. Often enough this attitude is found in other psychopaths, but never to the same degree as in the epileptic. Even hospitals for the insane, with their set and closed systems for inmate visiting, are revisited by former patients. But next to never do epileptics revisit the large home colonies to renew old associations. The reason for this is not that their sojourn was especially unpleasant so far as the institution's attitude toward them was concerned, but rather that the mild disciplinary measures—far less rigorous, perhaps, than those in force in other institutions—were so unpleasant that the ego smarts anew at the very recollection. In studying the mental content in the transitory deliria of epileptics, we often find that the epileptic's environment and associates are translated by his unconscious into conceptions of prisons and keepers. The egoistic striving is found to be shot through and through with the immediate daily conflicts, and if a little deeper content is touched, the concern is craftily sadistic or laden with distrust and suspicion. It may be confidently asserted, however, that under the new systems of care and training treatment for the epileptic, this unfriendly attitude is far less in evidence and a continued friendly feeling is more generally manifested. The latter is not a little encouraged by the self-knowledge which the epileptic is gaining of his own innate nature and the part it plays in his environment. It is not an uncommon experience now to find the epileptic himself standing out for a fair estimate of his internment in these colony homes and even insisting upon being returned there when affairs go badly with him in the outside world. This change is commented upon with surprise by relatives as entirely contrary to their former experiences. The epileptic is naturally courageous in more ways than one. While his behavior reactions are only too frequently reprehensible and antisocial, in many of his traits he shows a stout fiber altogether praiseworthy. If only he were as keen

upon a flexible and modifiable life process as he is upon a sense of justice to and from others, progress in eliminating his seizure reactions and many other vicious traits would be more rapid.

Antedating any modern conception of the epileptic as an individual problem, while for the most part he was recognized as possessing a seizure-reaction defect, many hospitals for such patients were provided in Germany, France, and Switzerland. The first step in the progress of organized care, however, was made by Germany, and down to 1891 the work was carried on largely through Christian benevolence. But even in 1773 the Bishop of Würzburg had established, in connection with the Julius Hospital, a home for the protection of indigent persons suffering from the so-called falling sickness. In 1845 a separate building was erected for epileptics, with accommodations for forty-eight free patients. Though Germany is in advance of other countries in making provision for epileptics, even there the accommodations for this class are far from being adequate. An important step affecting the welfare of epileptics was taken by the establishment of the Wuhlgarten Asylum at Biesdorf, near Berlin, in 1893. It was first planned for 500 patients, but was finally constructed to accommodate 1,100. It is built after the cottage plan.

In Switzerland there are three asylums for epileptics—one at Zurich, one at Rolle, and one at Schloss Tschugg. All these institutions are governed by private benevolent organizations and are under the supervision of the government. The asylum at Zurich was founded in 1886 by a society whose members belonged to the different cantons of the country and by a committee of men and women of Zurich. Epileptics are employed on the farm, in the gardens and vineyards, at the carpenter's bench, at tailoring, and in the binding of books. They also make carpets and shoes and do basket work. The adult female patients do women's handiwork of various kinds. There are two educational departments—the school proper for normally intelligent pupils and moderately feebleminded epileptics, and the preparatory school for decidedly feebleminded epileptics.

In the Bethel Colony for Epileptics, near Bielefeld, Germany, of which we shall give an account, the main incentive

to the project did not emanate from a scientific or medical source, but from a strong religious feeling and a broad humanitarian outlook toward the great need of making public provision for the unfortunate epileptic. The religious order has been the controlling factor throughout the colony's existence. This fact is less incongruous, however, when we note that the religious personnel as well as the medical staff have been trained essentially in the care and treatment of their charges; in other words, they possess the same fundamental understanding of the nature of the epileptic as is recognized in the best neuropsychiatric practice. One might think that the epileptic who is pious and pedantic in religious tendencies would seize eagerly upon the religious disciplines and avoid all the simpler efforts of industrious living. This situation might prevail were the religious contacts highly tinged with sentimentality, but throughout the whole administration at Bielefeld there apparently runs a strong impetus to translate the supportive influence of religious feeling into immediate and practical living. The results attained in the schools, shops, and farm activities attest this fact. From a small beginning the institution has had a natural and healthy growth, extending now over half a century of development. It has not confined its development solely to the noteworthy purpose of caring for the epileptic, for other types of individuals who need rest and care, including nervous and mental cases, are given aid and support. Possibly a somewhat diversified personnel has something to do with keeping the colony life from becoming too stereotyped. Again, the whole colony is in close proximity to Bielefeld itself, so that the less disabled colonists do not feel the intensive separation from normal contacts with the outside world which they often feel in the isolated colonies.

Situated at the foot of the Westphalian Mountains, the Bethel Colony was established by the Provincial Committee of the Inner Mission in Rhineland and Westphalia. The work was begun upon a small farm in 1867. To the small original farm tracts of land varying in size have been added from time to time, until the estate now includes about 3,000 acres. The settlement accommodates over 4,000 persons. One of its most noteworthy characteristics is its industrial system. Even patients of the first class who pay for care are not

released from a share in the labor, and no one with a fair degree of physical health is allowed to remain idle. Patients are preferably given outdoor employment at farming, gardening, taking care of stock, raising fruit, seeds, and so forth. There are some twenty shops and departments for indoor work, which includes printing and bookbinding, shoemaking and cabinet work, tailoring, saddlery, and basket making. Many patients are profitably employed in the iron foundry, tinshop, and blacksmith's shop. Brick making is an important industry. In fact a great variety of indoor and outdoor work is carried on, as in an ordinary village, including the conducting of a post office, a fire department, and the like. The hours of labor are so arranged as to leave time for recreation, for walking in the gardens and in the woods. Some patients receive compensation for their services in the form of pocket money, which is often used to aid their poor relatives. But all must work, not because it is of advantage to the colony, but for the benefit to themselves. Such a custom might be universally adopted with advantage in colonies for epileptics. In as much as the institution bears the expense of board and medical treatment, a limited remuneration is justified. However small the amount, it has been found that the idea of compensation has afforded contentment to the patient and satisfied a sense of justice, especially between those who did a great deal of work and those who did little or none. Contentment of mind is one of the most hopeful conditions for the epileptic, and a recognition of services rendered, however slight, fosters this feeling.

The Reverend von Bodelschwingh, who succeeded the first director, Reverend Simon, in 1872, in time became widely known as the pastor of the epileptics. He died in 1910 after thirty-eight years of service. He came to recognize that in Bethel there was work for physician, clergyman, and teacher alike, and that the colony was a benefit not only to the patients themselves, but to the entire community. This led to the establishment of trade schools in which the patients were trained for self-support. Work was provided for all, so far as possible, as it was recognized that it tended to increase the self-respect of the patients and to prevent introspection. As a result of the work policy, a large variety of

occupations were established and eventually factories were erected. The number of resident physicians gradually increased to thirteen, a number necessary to care for the 2,000 or more epileptics and a like number of insane and other homeless individuals. The number of clergy in attendance slowly increased to fourteen. The number of deaconnesses graduated since the beginning of the home is now 1,600, scattered among 400 stations. Originally male orderlies were obtained from other institutions, but later a special brother house was begun to train men especially for the work. Thus far, 300 brothers have been trained, and are working not only in Bielefeld, but in other home cities as well as in foreign missions.

Bielefeld naturally became a Mecca for vagabonds and homeless, and in the efforts of the management to care for them, farm colonies were established. Land in Bielefeld being too valuable, several colonies were established in suitable neighborhoods. In addition, a number of apprentice houses were instituted where the young were at the same time sheltered and taught trades.

In the United States, the first official expression in favor of special institutions for epileptics was made by the Ohio State Board of Charities. In 1868 the board called the attention of the legislature to the unhappy condition of epileptics in almshouses in the state and recommended that some better provision be made for them. The oft-repeated, patient appeals of the State Board of Charities at length met with recognition, and the legislature of 1877–78 passed a resolution authorizing the board to collect statistics and report their conclusions as to what public measure should be taken for the protection, comfort, and care of epileptics. In 1891 an appropriation of $40,000 was made for the erection of buildings for the "Asylum for Epileptics and Epileptic Insane", and in November of the same year the corner stone was laid. The hospital is situated on the Ohio River on the outskirts of Gallipolis. There are separate pavilions for men and women patients, an industrial building, a schoolhouse, and so forth, and patients are engaged at some industrial occupation so far as is consistent with their welfare. An effort is made to afford the patients as many opportunities for social, moral,

and religious improvement as are open to people in the ordinary walks of life.

In 1874 the state commissioner in lunacy for New York presented to the legislature a recommendation for the establishment of a state hospital for epileptics. It was not, however, until 1896 that the Craig Colony for Epileptics was established. The act to organize and establish a colony set forth that the object of such colony was to secure the humane, curative, scientific, and economical treatment and care of epileptics, exclusive of insane epileptics, to fulfill which design there was to be provided a tract of fertile and productive land, in a healthful situation, with an abundant supply of wholesome water. Cottages for dormitory and domiciliary uses were to be furnished, together with buildings for an infirmary, a schoolhouse, a chapel, and workshops for the proper teaching and productive prosecution of trades and industries; all of which structures were to be substantial and attractive, but plain and moderate in cost, arranged on the colony or village plan.

The site of Craig Colony at Sonyea, New York, is admirably adapted by nature for the humane purpose to which it is devoted through the wise benevolence of a great commonwealth. The landscape is exceedingly attractive, and the colony is situated about three miles from Mount Morris, a town of several thousand inhabitants.

Much stress has been laid at Craig Colony on the fact that entertainments, amusements for patients, and the like, are primarily part of the treatment, in as much as recreation properly arranged promotes a cheerful atmosphere. Provision is made for baseball, basket ball, and quoits, and occasionally a few patients are found who enjoy lawn tennis and croquet. Walks about the colony grounds and the adjoining country are permitted to some of the patients of good mentality who can safely take advantage of such opportunities. During the colder months the male patients make use of their club, which is equipped with pool and card tables, a player piano, and a reading room. Card tournaments and pool tournaments are held from time to time. Moving pictures are shown at frequent intervals, and there are dances for female patients and band concerts. An orchestra is main-

tained, the majority of the players being patients. Through the courtesy of the railroad company, about 250 patients are sent on an excursion annually to Portage. From time to time, when a circus comes to Mount Morris, patients are sent there, and occasionally, when an entertainment of some sort is given there, a group is permitted to go. In the cottages for the brighter patients, a sitting room is set aside in which a piano or phonograph is available as well as card games, and so forth. On the Fourth of July a field day is held.

As to occupational interests, trades, school instruction, and the like, occupation is selected primarily for its therapeutic value. Systematized occupation, recreation, reasonably restricted diet, and hygienic life are the foundation stones upon which treatment of the disorder is based, occupation often permitting of the inculcation of personal habits of discipline and self-control in a way that cannot be attained in any other manner. Institutions such as the colony are often criticized for not obtaining better results, and the fact is lost sight of that in order to accomplish anything, the patient must be mentally capable of understanding the situation and have insight into his or her condition to a degree that permits of coöperation. As the majority of patients received in any colony under existing conditions lack this degree of mentality, ideal results from treatment cannot be expected.

The brickyard at the colony not only affords interesting and valuable occupation to a number of patients, but turns out a product that can be utilized by other patients assigned to work on the farm, in mechanics, and so forth. The benefits to be obtained from work on the farm and garden are great, not only in the matter of permitting the individual to be outdoors and obtain exercise, but in the way of arousing and sustaining his interest. A few patients are engaged in forestry, cutting and thinning the woods and planting trees at the proper season.

In the trades school, departments are maintained for carpentry, plumbing, blacksmithing, tinsmithing, steam fitting, the making of willow ware, printing, mattress and broom making, shoe cobbling, tailoring, painting, and so forth. In the women's division a sewing room is operated in which all the bed linen used in the institution is made as well as a large

part of the garments worn by the patients. A few patients work with the baker, in the general storeroom and butcher shop; others with the dairyman, not only looking after the pasturing of cows, but assisting with the milking; others, again, work in the piggery. A number of patients take part in the various household occupations and some assist in the way of messenger service. The colony printing shop gets out all the forms used in the institution, as well as the annual reports and such booklets as are printed from time to time. Both male and female patients work in the laundry, the male patients in the wash room and the female patients at sorting and ironing clothes.

In regard to education,[1] the staff of teachers at the colony, a part of the faculty of the Geneseo State Normal School, has carried on its work very satisfactorily, the educational phase of the care of the younger patients having considerable bearing on the treatment of their disorder. While in some cases educational possibilities are materially limited, a goodly number find in school work normal outlets which they would be deprived of in the ordinary community. Considering the proportionate value of the educational work at the colony from every aspect, the pupil teachers, gaining as they do practical experience in the instruction of special types of children, really receive a valuable return from the present arrangement of colony school matters. From a practical standpoint, the occupation of adult patients at the colony cannot, for obvious reasons, be satisfactorily incorporated with the school work. Epileptic patients require more individual instruction than other children. This need not be carried to an extreme, however; it is possible to form groups according to ability. There is no doubt whatever but that many children who present symptoms of epilepsy in a moderate degree can carry on academic work very satisfactorily with benefit, not only in the way of an amelioration of their disorder, but to their general mental development. For the average epileptic child, the educational program should be such as to develop a reasonable knowledge of the English language, enough to permit of his being able to write letters, and to read with

[1] The following passage is abstracted from Craig Colony's annual report.

understanding ordinary books, magazines, and newspapers, perhaps, if necessary, to carry on certain simple business correspondence and to keep up with current topics—in short, to secure sufficient knowledge to meet the ordinary demands of life.

Hand work within reasonable limits is valuable for all children, whether epileptic or not, the degree of instruction desirable along this line varying, depending on the mentality of the patient and his ability to take up school work of other kinds. Hand work may consist of weaving, Sloyd, chair caning, basket making, gardening, and the like. A considerable amount of mental ability on the part of the patient is required in order to carry on these occupations successfully.

A broader view could be taken toward domestic science, so as to make it of practical value in the routine of the colony. Much benefit might also be derived from instruction in dressmaking, embroidery, knitting, crocheting, and so forth, as patients so trained could render much assistance later in manufacturing various articles for use in the institution. For older patients, bookbinding and metal work have often been a means of arousing interest and incidentally can be of some remunerative value to the institution.

School gardening should be carried on in close proximity to the school building, where practical observations could be made not only as to preparation of the ground, sowing of seed, cultivation of crops, and so forth—*i.e.*, the principles of agriculture—but to certain arithmetical problems which should be worked out for the purpose of inculcating habits of accuracy. Practical gardening on a large scale, or what might be termed advanced gardening, lies within the province of the regular gardener.

Physical training should include folk dancing, ordinary dancing, various drills, games, and gymnastics, the latter preferably given outdoors when the weather permits. Music, singing, and dramatization are especially important phases of educational work for epileptics, the degree to which these activities can be developed depending, of course, upon the resources available.

Older patients who were perhaps deprived during earlier years of educational opportunities and are desirous of in-

creasing their information on various school matters can be cared for in evening classes. Educational work in an institution, particularly one such as the Craig Colony, must be considered from a broader viewpoint than that of merely imparting information. The habits of discipline inculcated, the interests developed and aroused, the self-control acquired, the encouragement to the patients to feel that they are not so different from other people, the manners taught, are especially valuable for this particular type of child and cannot do otherwise than have a beneficial effect in the matter of the recurrence of seizures, providing due consideration is given to the length of the school periods and a proper estimation is made of the ability of the individual child to carry on the work.

The opinion generally held by those who are treating epileptics is that education is as important for the epileptic child as for the normal child, if not more so, with the understanding, of course, that the program adopted is to be modified to suit the particular individual. It is agreed that the badly trained epileptic is a burden to those who care for him, whether in an institution or in a family. While a scholastic education will not entirely correct the faults observed in many epileptic children, nevertheless it will do much toward correcting some unfortunate traits.

The consensus of opinion is that association with others suffering from the same malady cannot on the whole be deemed disadvantageous. It sometimes has quite an educational effect upon an epileptic to see others in a seizure. While for the occasional epileptic such an experience may at first prove depressing, nevertheless he soon acquires a realization of how much those who care for him during a seizure have to bear. One is impressed, in institutions for epileptics, by the readiness with which patients care for one of their number who has a seizure. It was long ago brought out that epileptic children outside of an institution are often avoided by other children both in school work and at play, finding no sympathy because they are a little less fortunate than normal children.

It has been proven at Craig Colony, as elsewhere, that despite the irregularity of school attendance because of seizures, the varying mental condition of many of the individual pupils, and the occurrence of seizures in class, a selected

group of epileptic school children can and do make quite satisfactory progress.

Among other places for epileptics throughout the United States we may mention the Massachusetts State Hospital for Epileptics at Monson; the Hospital Cottages for Children at Baldwinsville, Massachusetts; the New Jersey State Village for Epileptics at Skillman; the Pennsylvania Epileptic Hospital and Colony Farm at Oakburne; the Indiana Village for Epileptics at New Castle; the Michigan Epileptic Farm Colony at Wahjamega; the Ohio Hospital for Epileptics at Gallipolis; the Hospital for Epileptics at St. Charles, Missouri; the Texas Hospital for Epileptics at Abilene; and the Hospital for Epileptics at Parsons, Kansas. Four institutions that care for the feebleminded as well as the epileptic are the Hospital for Epileptic and Feebleminded at Madison Heights, Virginia; the Colony for Feebleminded and Epileptic at Mansfield Depot, Connecticut; the Hospital for Epileptic and Feebleminded at Woodward, Iowa; and the Missouri Colony for Feebleminded and Epileptic at Marshall, Missouri.

There are two private institutions in the United States, one the Emmaus Asylums at Marthasville, Missouri, and the other the Passavant Memorial Homes for the Care of Epileptics at Rochester, Pennsylvania.

In many states separate provision for the epileptic has not yet been made. In many instances insane epileptics are provided for as insane persons, and only too often sane epileptics suffer the real injustice of being confined with insane persons.

In the province of Ontario, Canada, there is the Hospital for Epileptics at Woodstock.

Germany has fifty institutions with a special provision for epileptics, Switzerland three, and Holland two. Belgium also makes provision for epileptics. England now has nine institutions, of which four or five are of considerable size. Australia has one.

It is an interesting fact that whatever the keynote of the various institutions may be, the final objective of them all is proper care and training treatment of the epileptic *as an individual.* At the Bethel Colony the religious note is emphasized; at the Lewis Colony in England home industries and ethical training are given most stress; while at Craig Colony, Gallipolis, and Palmer scientific study of the epileptic reaction

process is perhaps the immediate aim. In spite of this seeming disparity of purpose, the spirit and effect of the activities of all these colonies are in the last analysis much the same.

While sedative and drug therapy and other physical treatment still have their place in the various institutions in which the epileptic is interned, a wiser attitude has recently come about. Epileptics *en masse* have made the psycho-biologic defect of the epileptic make-up so obvious that the majority of the physicians in charge have given up a strictly medical approach for the broader principles of retraining the epileptic as an individual. Partial reactions are the subject of inquiry both clinically and pathologically, and certain principles in accord with our thesis have become recognized as fundamental.

First, a large grant of land is necessary to permit the housing of epileptics in small groups. It is now tacitly recognized that the epileptic is fundamentally unsocial and demands as small a grouping as possible. This situation is distinctly different from that of the insane and feebleminded, whose gregariousness is well known. Nor does this principle apply solely to the housing quarters of the epileptic, but is equally applicable to all his other living conditions. Many types of work and trade must be supplied. Efforts to make the epileptic a good mixer have been largely abandoned and, instead, his training is carried on along the lines of the upbuilding of his own innate nature and the promotion of objectivated interests. In the period when physicians were concerned mainly with the convulsive phenomena of epilepsy, the duties of caring for and training the individual were largely confined to laymen. It is a goal worth striving for, to furnish wise counsel and personal guidance to the patient interned in public colonies, so that one might look upon these institutions as training schools for social workers and various laymen engaged in educational and religious work.

In view of the natural disadvantages of the colonies for the proper training of the epileptic individual as a whole, and in face of the fact that but a relatively small percentage of all epileptics who need educational training can be received, a certain proportion of the accommodations of the existent colonies should be devoted to the temporary training of epileptics who must reside in their own homes and perhaps be properly supervised by the district clinics now in process of

formation in many states. At present there are not less than three hundred thousand epileptics at large in the United States. Even epileptics in whom there has been an arrest of seizures should remain under supervision after their discharge from the colonies. Many relapses might be thus prevented. Just how this after-care supervision can be inaugurated has still to be carefully considered.

Perhaps more can be done in the way of improving the social status of the well-to-do or semi-independent epileptic than of those entirely dependent upon state care and aid. In the past, in private practice, epileptologists have usually endeavored to remove the patient from his immediate home surroundings and place him with a nurse trainer in a quiet rural environment. Under such an arrangement a fine social backing of normal contacts may be more or less evenly maintained, but on the other hand the patients fail to gain coöperative control of their more pronounced egoistic tendencies. Unfortunately the residents in these rural community settings do not comprehend or coöperate with the main purpose of the plan. They either shun the epileptic or sentimentally overindulge his eccentricities to his detriment. It is a moot question just how closely the epileptic can dwell with normal individuals to his advantage. Undoubtedly close interning, even with others similarly afflicted, does him harm. On the other hand, the stressful demands of close association with normals may do him great harm. The liberty to be allowed the epileptic must be determined in each individual case and often varies with the state of his health. Much solicitude prevails as to his safety in seizures. A few instances of mishaps may restrict the very great good of the many, for on the whole one can afford to grant a fair degree of liberty to the epileptic interned under private or public care. Certainly no more frequent or greater mishaps seem to occur when little restriction is employed. "Safety first" might be the ruling principle here, were it not for the fact that if carried to an extreme, it acts as a constant source of irritation in the daily life of the epileptic. To allow him to take a fair number of chances is a much better guiding rule. No one has precisely measured the disastrous effects of complete and final segregation of the epileptic. No doubt many cases show their first definite signs of deterioration after being interned.

In segregating the epileptic, the main purpose is to study his life-reaction faults, to find the reëducational methods adapted to his individual needs, and to prepare the more favorable cases to return to community and home. When the simpler plan outlined above fails, then it becomes necessary to try a grouping of the more hopeful cases on a family plan. Simply to provide such a group with opportunities to engage in gardening, woodcutting, handicrafts, and other types of healthful occupation fails unless there is a fairly high degree of social *rapport* and plenty of amusements for recreation periods. Men and women should be grouped together, and it is best to pattern when possible after the large family group, including both adults and children. An environment requiring too much "roughing it", such as camping, is usually bad, as epileptics are for the most part quite conventional and cannot stand pioneering. They also do poorly if they are changed frequently from place to place. Epileptics are committed to routine and are notoriously inflexible to new adaptations. In the main the third principle in private segregation is to unify the habits and mental attitudes of the epileptic so that he may reënter and maintain a place in a normal community and home. To do this one must bring the home influence into the segregation plan. When feasible, it is desirable to have in the same home a mixed group—for instance, a few persons suffering from other types of nervous invalidism, and even a few normal individuals. If the rigid mentation of the epileptic does not allow him to get on in a normal environment, the latter must be brought to him as naturally as possible; hence lectures, talks, radios, and moving pictures which will keep him in touch with the outside world should be provided. Imitating in part the diversified occupations of the original colony founded at Bielefeld, one may encourage the actual manufacture of various products, such as women's apparel, toys, and the like, the repair of old furniture, and so forth, making the work as far as possible individual. Even collective work such as gardening should be so subdivided that each patient will have his special duties. One may rightly infer that on this principle we are working with, instead of against, the innate tendencies of the epileptic temperament, but in so doing we are taking him as he really is and are simply requiring him to exercise so far as possible the abilities he believes

he possesses. The main purpose is to inculcate continued spontaneous interests and healthful activities. No mere perfunctory effort in this direction will prove lasting or satisfactory.

As for educational training in the trades, many private clubs for epileptics might be profitably maintained near small college towns, especially near agricultural or industrial schools where special-class instruction can be procured. My own club group was stationed for one season near an agricultural college and each patient took one or more of the summer courses. Normal associations in the small community at the college were even better than in the ordinary rural communities. Many of the patients joined in the town activities, attended dances and entertainments, and so forth. It should be borne in mind, however, that as the average epileptic is capable of only about one-third the normal person's capacity for prolonged physical and mental effort, one should see to it that the school instruction is not too taxing. There should also be a diffused generalized training in all the ordinary hygienic principles of diet, work, amusements, and home discipline. A proper coöperation on the part of the domestic personnel helps greatly, as every epileptic should be made to feel that he is to some degree an integral part of the home group and as much of his active coöperation in the general welfare as possible is an essential part of his well-being. For social gatherings, lectures, talks, books, magazines, and games are helpful. It should be possible even in these small home groupings to form a cohesive club for the disciplinary welfare of its members. If they cannot be counted upon to act as direct promoters of social betterment in a positive manner, they at least can discuss to what limit individual liberty may be comfortably permitted without interfering with the rights and privileges of others. Many an epileptic individual's keen social antagonisms have been favorably modified by such conferences. Finally, the whole club plan must be a vital and integral emanation of a medical and nursing personnel that has the epileptic's welfare at heart as well as an understanding of his needs, so that any lack of appreciation on the part of their charges may not work against the unwearying services that they are called upon to give.

FEEBLEMINDED IN INSTITUTIONS IN THE UNITED STATES*

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THAT institutional care of the feebleminded is rapidly increasing in every part of the United States is clearly evidenced by the report of the special federal census of institutions which will soon be published. This census covered the resident patients on January 1, 1923, and the admissions, discharges, and deaths for the calendar year 1922. The total number of patients enumerated in special institutions for the feebleminded in such census was 42,954, as compared with 20,731 in 1910 and 14,347 in 1904. Rates per 100,000 of general population in the three census years were: 1923, 39.3; 1910, 22.5; 1904, 17.5. The increase from 1904 to 1910 was 44.5 per cent and from 1910 to 1923, 107.2 per cent. As a slight offset to this increase, it is found that the number of feebleminded reported in almshouses decreased from 16,551 in 1904 to 12,183 in 1923. The number of states that reported feebleminded patients in special institutions increased from 24 in 1904 to 30 in 1910 and to 43 in 1923.

The census covered 136 institutions, including 55 state institutions for feebleminded, 2 state hospitals for mental disease caring also for feebleminded and epileptic, 12 Federal Government hospitals caring for all three classes, 1 city institution for feebleminded, and 66 private institutions for feebleminded. The special census of the feebleminded in 1910 covered only 63 institutions, of which 35 were public and 28 private.

Data showing the changes in the patient population in the special institutions for feebleminded in the several states are given in Table 1. It will be observed from the rates shown in the table that the special care of the feebleminded is much

* Summary of results shown by the Federal Census of 1923.

better developed in some sections of the country than in others, the East South Central and the West South Central divisions being far behind the others.

TABLE 1.—PATIENTS IN INSTITUTIONS FOR FEEBLEMINDED BY DIVISIONS AND STATES: 1923, 1910, AND 1904.*

Division and State	1923		1910		1904	
	Number	Per 100,000 of total population	Number	Per 100,000 of total population	Number	Per 100,000 of total population
United States	42,954	39.3	20,731	22.5	14,347	17.5
Geographic divisions:						
New England	5,009	65.7	2,012	30.7	1,161	19.5
Middle Atlantic	13,393	58.2	6,766	35.0	4,538	26.9
East North Central	10,323	46.3	5,941	32.6	4,571	27.2
West North Central	6,547	51.2	3,906	33.6	2,888	26.7
South Atlantic	2,444	16.9	584	4.8	338	3.1
East South Central	621	6.9	330	3.9	189	2.4
West South Central	739	7.0	19	0.2	....	....
Mountain	731	20.8	160	6.1	14	0.7
Pacific	3,147	53.2	1,013	24.2	648	21.2
New England:						
Maine	467	60.3	62	8.4	....	....
New Hampshire	393	88.1	144	33.4	64	15.3
Vermont	179	50.8	....	....	....	....
Massachusetts	3,034	76.3	1,464	43.5	878	29.2
Rhode Island	377	60.8	48	8.8	....	....
Connecticut	559	38.6	294	26.4	219	22.3
Middle Atlantic:						
New York	7,278	67.9	3,421	37.5	2,135	26.9
New Jersey	1,633	49.3	640	25.2	460	21.7
Pennsylvania	4,482	49.8	2,705	35.3	1,943	28.6
East North Central:						
Ohio	2,510	41.7	1,526	32.0	1,125	25.7
Indiana	1,565	52.4	1,135	42.0	1,036	40.1
Illinois	2,458	36.7	1,265	22.4	1,283	25.1
Michigan	2,132	54.8	986	35.1	516	20.1
Wisconsin	1,658	61.2	1,029	44.1	611	28.2
West North Central:						
Minnesota	1,892	76.7	1,194	57.5	888	47.5
Iowa	1,596	65.1	1,189	53.4	981	44.0
Missouri	779	22.7	512	15.5	250	7.9
North Dakota	338	50.8	145	25.1	....	....
South Dakota	424	65.2	‡	....	51	10.9
Nebraska	751	56.8	446	37.4	337	30.3
Kansas	767	42.9	420	24.8	381	24.6

* Ratios for 1923 and 1904 are based upon estimated total population.

TABLE 1.—PATIENTS IN INSTITUTIONS FOR FEEBLEMINDED BY DIVISIONS AND STATES: 1923, 1910, AND 1904.*

Division and State	1923 Number	1923 Per 100,000 of total population	1910 Number	1910 Per 100,000 of total population	1904 Number	1904 Per 100,000 of total population
South Atlantic:†						
Delaware	50	21.9	....	....	....	....
Maryland	773	51.9	310	23.9	162	13.2
Virginia	644	27.1	60	2.9	35	1.8
West Virginia	359	23.5	214	17.5	141	13.4
North Carolina	308	11.6	....	....	....	....
South Carolina	123	7.1	....	....	....	....
Georgia	47	1.6	....	....	....	....
Florida	140	13.7	....	....	....	....
East South Central †						
Kentucky	531	21.7	283	12.4	189	8.6
Tennessee	15	0.6	47	2.2	....	....
Mississippi	75	4.2	....	....	....	....
West South Central:						
Arkansas	7	0.4	....	....	....	....
Louisiana	170	9.3	....	....	....	....
Oklahoma	330	15.5	....	....	....	....
Texas	232	4.8	19	0.5	....	....
Mountain:†						
Montana	91	15.3	51	13.6	....	....
Idaho	253	55.1	....	....	....	....
Wyoming	128	61.9	....	....	....	....
Colorado	259	26.5	64	8.0	14	2.2
Utah	‡	....	45	12.1	....	....
Pacific:						
Washington	803	56.9	159	13.9	81	10.9
Oregon	675	83.1	....	....	....	....
California	1,669	45.1	854	35.9	567	31.3

* Ratios for 1923 and 1924 are based upon estimated total population.
† States for which no institutions were reported in 1923 or in 1910 are not shown.
‡ Not reported.

Table 1 is not to be construed as indicating the relative frequency or relative increase of feeblemindedness in the several states. In the absence of a thoroughgoing survey of the population both in and out of institutions, it is impossible to compare the prevalence of feeblemindedness in one state with that of another or to reach any conclusion as to the increase of mental defect in the population.

MENTAL STATUS

In classifying the feebleminded according to mental status, the terms adopted by the American Association for the Study

of the Feebleminded in 1920 were used—namely, *idiot, imbecile,* and *moron.* These terms were defined as follows:

An "idiot" is a mentally defective person having a mental age of not more than 35 months, or, if a child, an intelligence quotient of less than 25.

An "imbecile" is a mentally defective person having a mental age between 36 months and 83 months, inclusive, or, if a child, an intelligence quotient between 25 and 49.

A "moron" is a mentally defective person having a mental age between 84 months and 143 months, inclusive, or, if a child, an intelligence quotient between 50 and 74.

Of the 42,336 feebleminded patients in institutions for whom individual schedules were received, 6,642 were classified as idiots, 20,161 as imbeciles, 14,636 as morons, and 897 as unclassified. The sex distribution of these patients was as follows:

	Male	*Female*	*Total*
Idiot	3,351	3,291	6,642
Imbecile	10,495	9,666	20,161
Moron	6,643	7,993	14,636
Unclassified	451	446	897
Total	20,940	21,396	42,336*

* Six hundred and eighteen other patients in institutions for feebleminded were not reported as feebleminded.

The 7,009 feebleminded first admissions for whom schedules were received were classified by sex and mental status as follows:

	Male	*Female*	*Total*
Idiot	594	470	1,064
Imbecile	1,552	1,098	2,650
Moron	1,658	1,406	3,064
Unclassified	115	116	231
Total	3,919	3,090	7,009*

* Two hundred and fifty other first admissions to institutions for feebleminded were not reported as feebleminded.

The excess of males among first admissions is probably due to the fact that females live a more sheltered life and consequently have less difficulty in meeting demands made upon them.

As the feebleminded admitted to institutions consist principally of those who are unable to make adequate social

adjustments, the proportion of idiots and imbeciles among feebleminded first admissions is naturally much greater than among the feebleminded in general.

RACE

Of the 42,954 patients in institutions for the feebleminded on the date of the census, 41,936, or 97.6 per cent, were white; 980, or 2.3 per cent, were Negro; 37, or 0.1 per cent, of other races, including 30 Indians, 5 Chinese, and 2 Japanese; and 1 was of unknown race. The rate per 100,000 population of same race was 44.2 for the white race and 9.4 for the Negro. This of course does not indicate that feeblemindedness is less frequent among Negroes than among whites, but that relatively more institution provision is made for white defectives. The only Southern state caring for Negro feebleminded in institutions was Louisiana, which reported 71 Negro patients.

Of the 7,259 first admissions, 6,983, or 96.2 per cent, were white; 264, or 3.6 per cent, Negro; and 12, or 0.2 per cent, of other races or unascertained. The rate per 100,000 of the same race was 7.4 for the white race and 2.5 for the Negro. In New York State the rate for the whites was 14.6 and for the Negroes 36.8. In Massachusetts the rates were 8.4 and 28.6 respectively. The high rates among Negroes in these two states in which Negroes are admitted without discrimination seem to indicate a greater prevalence of feeblemindedness among Negroes than among whites.

NATIVITY

Of the 41,936 white patients in institutions for feebleminded, 38,360, or 91.5 per cent, were native; 1,866, or 4.4 per cent, were foreign born; and 1,710, or 4.1 per cent, were of unknown nativity. The rate of patients per 100,000 of population was 47.3 for the native whites, and 13.6 for the foreign-born whites. The low rate among the foreign born is due in part to the relatively few children among them and in part to the fact that immigrants found to be feebleminded are not permitted to enter this country. Furthermore, many feebleminded immigrants who escape detection at the port of entry are later deported.

Of the 6,983 white first admissions, 6,365, or 91.1 per cent, were native; 283, or 4.1 per cent, foreign born; and 335, or

4.8 per cent, of unknown nativity. The rate of first admissions per 100,000 population of same nativity was 7.8 for the native whites and 2.1 for the foreign-born whites.

ENVIRONMENT

Of the 7,259 first admissions, 4,615, or 63.6 per cent, were classed as urban; 2,239, or 30.8 per cent, as rural; and 405, or 5.6 per cent, as unknown with respect to environment. The rate of first admissions per 100,000 population was 8.5 in urban districts and 4.4 in rural districts. The rate for males was 9.6 in urban districts, and 4.5 in rural districts. The rates for females were 7.4 and 4.1 respectively. These rates, while constituting a true comparison of first admissions to institutions for feebleminded, cannot be taken as indicating the relative prevalence of feeblemindedness in urban and rural districts. As social adjustment in cities is much more difficult than in rural districts, it is probable that a larger proportion of the feebleminded of the cities are committed to institutions.

The rates in urban and rural districts are also affected by the more adequate provision made for the care of the feebleminded in cities than in rural districts. The states with large urban populations as a rule are also better provided with institutions than the states with relatively large rural populations. In some states, which make equal provision for both the urban and rural feebleminded, the rate for rural districts is considerably higher than that for urban districts.

READMISSIONS

In institutions for the feebleminded, readmissions are of comparatively little significance. The total feebleminded readmissions reported for the year 1922 numbered 434, of which 309 were males and 125 females. These were distributed in the mental-status groups as follows:

	Male	*Female*	*Total*
Idiot	20	16	36
Imbecile	98	55	153
Moron	188	49	237
Unclassified	3	5	8
Total	309	125	434

DISCHARGES

There were 2,964 discharges from institutions for feebleminded in the year 1922. Of these 1,703 were males and 1,261 females. The rates of discharges per 100 admissions were: males 38.8, females 37.9, total 38.4.

Of the total discharges 35.5 per cent occurred within less than one year of institution life and 26.8 per cent after an institution life of five years or over. The discharged males had a shorter institution life than the discharged females. This is in accordance with the general belief that the female patient needs the protection of the institution to a greater degree than the male.

DEATHS

The deaths in institutions for the feebleminded in 1922 totaled 1,347. Of these patients, 764 were males and 583 females. The death rates per 1,000 under treatment were: males 32.3, females 24.8, total 28.5. This rate is low compared with the death rate of 39.5 reported in the census of the feebleminded in institutions in 1910.

The death rate in 1922 varied greatly in the several mental-status groups, being 68.7 among idiots, 26.7 among imbeciles, and 10.1 among morons. In each group the death rate among males was higher than among females.

The most prominent causes of death in institutions for the feebleminded were tuberculosis of the lungs, epilepsy, bronchopneumonia, lobar pneumonia, diarrhea and enteritis, influenza and nephritis.

The complete report of the Federal Census Bureau presents a vast amount of interesting data concerning the feebleminded in the several states and reveals the marked progress that has been made in dealing with this group of defectives since the census of 1910. Custodial care in almshouses is rapidly being superseded by enlightened treatment in special institutions, and year by year larger proportions of the feebleminded are receiving the care and attention required for their own protection and training and for the welfare of the community.

CHARLES W. ELIOT

Resolution Adopted by The National Committee for Mental Hygiene at Its Seventeenth Annual Meeting, November 11, 1926

Charles W. Eliot died at his summer home at Northeast Harbor, Mt. Desert, on August 22, 1926, at the age of ninety-two. Thus ended a life of unique value, consistently dominated by devotion to the pursuit of truth and to the furtherance of the spiritual well-being of his fellows. The lofty conceptions of President Emeritus Eliot were not dissociated from concrete circumstances and particular applications, and when the formation of The National Committee for Mental Hygiene called attention to an important social need, he gave to the new movement his whole-hearted support. On April 5, 1913, Dr. Eliot was elected vice-president of The National Committee for Mental Hygiene, and during the following years he continued to watch with undiminished interest the growth of its work. So long as his physical health allowed it, he gave generously of his time and energy in the service of mental hygiene; when unable to be present at the meetings of the National Committee in New York City, he still attended regularly the meetings of the directors of the Massachusetts Society for Mental Hygiene, and by his presence and his wise counsel he contributed largely to the successful work of that society. On repeated occasions he expressed the hope that those of wealth would look upon the endowment of the mental-hygiene movement as an opportunity and a privilege.

To those responsible for the policies and the finances of The National Committee for Mental Hygiene, it was of incalculable benefit to have the unfailing support of a man who for forty years had guided the destinies of a great American university and to whom the whole nation had become accustomed to look for guidance in regard to fundamental human problems.

The National Committee for Mental Hygiene takes this opportunity to place on its records its appreciation of the rare intellectual and spiritual distinction of its late vice-president, who not only by precept, but still more by the actual conduct of his life, helped his fellows to realize the principles of mental hygiene.

Whereas, The National Committee for Mental Hygiene has suffered an irreparable loss in the death of Dr. Charles W. Eliot; and

Whereas the cause of mental hygiene has in his death been deprived of a great leader;

Be It Therefore Resolved that The National Committee for Mental Hygiene expresses to the family of Dr. Eliot its profound sorrow and deepest sympathy in their bereavement; and

Be It Further Resolved that a copy of this resolution be sent by the Secretary of The National Committee for Mental Hygiene to Dr. Eliot's family.

ABSTRACTS

Incipient General Paralysis; A Study of the Earliest Symptoms Presented By Seventy-four Cases. By Henry A. Bunker, Jr., M.D. *American Journal of the Medical Sciences,* 171:386–97, March, 1926.

Loss of Weight: Its Importance as an Early Symptom in General Paralysis. By Henry A. Bunker, Jr., M.D. *Archives of Neurology and Psychiatry,* 16:63–70, July, 1926.

The Signifance of Gain in Weight in the Malaria Treatment of General Paralysis. By Henry A. Bunker, Jr., M.D. *Archives of Neurology and Psychiatry,* 16:329–43, September, 1926.

The first of these papers is the report of an attempt to ascertain as accurately as possible the earliest symptoms that made their appearance in the cases of 74 male patients committed to the Manhattan State Hospital with fully developed general paralysis. The cases were for the most part selected with the intelligence and observational ability of the informant (usually the wife) in mind, so that the data obtained probably give a fairly faithful picture of these patients at a stage in the evolution of their disease before they had begun to present any of the symptoms commonly regarded as characteristic of general paralysis or any form of neurosyphilis. The study was undertaken with the idea that "if the occurrence of certain symptoms can be shown to carry with it the possibility that, if not otherwise to be accounted for, they may have their origin in neurosyphilis, and perhaps even in the more malignant form of that condition known as general paralysis, this fact will suggest the necessity for examination of the spinal fluid in numerous instances in which this procedure is not now carried out."

Since the real purpose of his paper is to point the way to an earlier diagnosis of general paralysis, Dr. Bunker precedes the discussion of his case material with a brief statement of the indication for spinal-fluid examination, without which a diagnosis of neurosyphilis is often well-nigh impossible and a diagnosis of general paralysis in its early stages is practically out of the question. There are three kinds of phenomena the occurrence of any one of which suggests the desirability of a lumbar puncture, while if two occur together, a spinal-fluid examination is distinctly indicated.

1. The first is a positive Wassermann reaction in the blood. While a persistent negative Wassermann reaction in the blood is not uncommon among neurosyphilitics, a positive reaction always means the possibility of neurosyphilis. A positive blood reaction was found in an appreciable proportion of the patients in Dr. Bunker's series who consulted a physician early. "Almost without exception, however, no effort was made, in spite of this fact and of the complaint of definite 'nervous' symptoms as well, to establish the presence or absence of neurosyphilis. These same patients accordingly received antisyphilitic treatment of a purely routine character, such as might conceivably have had a favorable influence upon neurosyphilis of the meningovascular, and hence relatively 'benign' type, but could not possibly be effective against the parenchymatous or 'malignant' form of the disease from which these particular patients, as the event only too clearly proved, were beginning to suffer."

2. Even without a positive reaction in the blood, certain physical symptoms strongly suggest and sometimes practically prove the presence of neurosyphilis. Unequal or irregular pupils or pupils that react to light with impaired briskness or degree of excursion are highly suspicious, while the true Argyll-Robertson pupil is "practically pathognomonic of syphilitic involvement of the central nervous system". Absence or definite inequality of the knee jerks or the ankle jerks is also very suggestive. While the absence of any or all of these signs does not exclude the possibility of neurosyphilis, when they are definitely present, they emphatically call for an examination of the spinal fluid.

3. The third indication for a lumbar puncture consists of certain symptoms, both physical and mental, which are in themselves relatively or absolutely undistinctive, but which occur with some prominence as the earliest manifestations of clinical neurosyphilis in many cases and are at least equally characteristic of the earliest onset of general paralysis. In the presence of either of the two phenomena already mentioned, even the least distinctive of these symptoms may be extremely significant. And in any case, their occurrence, when they cannot be adequately accounted for on other grounds, should raise the question of a neurosyphilitic origin. "Indeed, it may be laid down as a rule that the presence of any nervous or mental symptom whatever, if that symptom cannot be explained beyond reasonable doubt on some other basis, is cause for making an examination of the spinal fluid; such is the protean character of neurosyphilis and of its subspecies, general paralysis."

Inquiry into the case histories of the 74 patients in Dr. Bunker's series showed that these ambiguous early symptoms, even when accompanied by a positive Wassermann in the blood, were in almost every

case disregarded or misinterpreted because their possible significance was not appreciated. Yet in view of the striking results obtained by the use of tryparsamid and malaria in early cases of general paralysis, recognition of the disease in its first stages has assumed a new importance.

The early symptom most commonly reported in the patients under investigation was irritability. This symptom was among the first noted in 42 of the 74 cases. In 18 it was the earliest departure from normal observed by the informant; in 12 it followed some other symptom after a period of from one to six months; in the others it was the third to appear, but in most of these its appearance was more or less simultaneous with that of the second symptom. "When this alteration in the personality of the patient was the first deviation from the normal to appear, it usually antedated the onset of frank mental symptoms by at least six months and not infrequently by a year, a year and a half, or even longer." Though irritability is far from being a distinctive symptom, Dr. Bunker is of the opinion that its occurrence in more than half of the present series of cases suggests the desirability of excluding general paralysis as its possible cause in patients in whom it makes its appearance.

Another early symptom commonly noted is a condition often characterized by the informant as "quiet". "The patient is described as gradually, but noticeably, becoming less active than is his ordinary habit; he becomes less communicative and may sometimes gradually lose almost all spontaneity of utterance; he often appears preoccupied, listless, or apathetic; he wants to be let alone and is averse to the company of others, especially strangers, often leaving the room upon the advent of visitors; he loses interest in some of the things which formerly entertained him." This condition was given as among the earliest noted in 28 of the 74 cases, being the first change observed in 12 patients and the second in 10. It was usually first noted at least nine months before the onset of a frank psychosis. In one case it had been present for four years and in another for four and three-quarter years prior to commitment.

Next in numerical importance among earliest symptoms was loss of weight. This was noted in 22 cases—in 13 as the earliest symptom observed and in 9 as preceded by one other symptom. Its onset was difficult to date exactly, as loss of weight is not usually noticed until it amounts to at least five or ten pounds, but the interval between the time when it first came to the attention of the informant and the time when frank mental symptoms appeared was never less than from four to six months, and was usually a year or longer, being in one case at least two years, in 3 cases more than three years, and in one case nearly five years. The amount and rapidity of the loss varied widely

in the different patients. "A loss of ten or fifteen pounds, often at the very onset, was almost invariable, since this would usually be nearly the smallest amount of loss discernible by the observer; a loss of some twenty-five pounds took place within the first six months or so in several cases; and 3 patients lost a total of thirty-five pounds in weight, two of these within a year of onset. So far as this particular series is concerned, loss of weight appears, therefore, to assume some importance among the earliest symptoms of general paralysis because of its relative definiteness as a symptom, its early appearance and sometimes rather conspicuous character in an appreciable proportion of cases, and the fact that early and especially fairly well-marked loss of weight characterizes but few diseases—among which diabetes, hyperthyroidism, and tuberculosis come most readily to mind."

Forgetfulness, a characteristic symptom of fully developed general paralysis, was mentioned as among the earliest departures from normal in only 15 of the 74 cases. In only 5 of these was it given as the first symptom; in 7 it was the second. In one case it was noted by the patient's wife three years before the outbreak of acute mental symptoms. It is a symptom, however, that might very well escape the notice even of the patient's intimates for some time, though he himself might be aware of it. It is more distinctive than any of the first three symptoms mentioned in that its definite appearance *de novo* suggests either cerebral arteriosclerosis, on the one hand, or cerebral syphilis or general paralysis, on the other.

In 15 cases an increased tendency to sleep, another characteristic of organic brain disease, was among the earliest symptoms. In 8 it was the first noted, but in 4 of these it was considered as practically simultaneous in appearance with at least one other symptom. In 6 cases it was the second symptom. While in most cases it manifested itself only a few months before the outbreak of the psychosis, in 3 it was present at least a year before that event.

Insomnia was an early symptom in 9 cases, in 2 of which it was given as the first. There was only one case in which its appearance antedated by a considerable period the onset of acute mental symptoms. In any event, it is obviously wholly undistinctive as a symptom.

Speech defect, a symptom in many cases of fully developed general paralysis, was one of the earliest symptoms in 11 of this series, the first noted in 5, in all of which it appeared some time before the outbreak of the frank psychosis—from seven months in one case to almost six years in another. In two cases, its onset was sudden.

Another phenomenon commonly associated with general paralysis is defective judgment. The first deviations from the normal in this

respect, however, are hard to detect, since it is difficult to say just what constitutes good or bad judgment—"to weigh the circumstances accurately enough to know whether a faulty investment or an ill-advised change in business, for example, was in fact an actual sign of the disease that was to develop a year or more later". Defective judgment was given as the earliest symptom in only 7 of the patients of this series. "In 3 of these the defect seems nevertheless to have been of the grosser order, an increasingly obvious mismanagement of their business which antedated other symptoms by a few months only. In 3 the situation was more difficult to estimate, the defective judgment manifesting itself four, six, and nine months, respectively, before the appearance of any other symptom. In the seventh case it was learned from the patient himself, after he had achieved a very complete remission following malaria treatment, that nearly a year and a half prior to the onset of other symptoms he had diverted funds of his in a way that to him was clear evidence, seen in retrospect, of mental disorder."

The remaining early symptoms are of a physical nature and each was reported for a few patients only. They are fatigability, noted early in 7 patients; digestive disturbance, also noted in 7; impairment of vision, the earliest abnormality mentioned in 6 cases; headache, noted in 4; tremor, usually of the hands, in 4; a slowing up of movements, in 3; rheumatoid pains, in shoulders, arms, or legs, in 4; and numbness, first of the right foot and then of the right hand, in one.

"Of the foregoing symptoms which in this series have been the earliest to appear in cases of incipient general paralysis," Dr. Bunker concludes, "it is clear that only three are in themselves at all suggestive of that disease, or of neurosyphilis of any type. These are speech defect, memory defect, and judgment defect. The last named, though significant, is of reduced value because of the difficulty of establishing its presence; the existence of the first or second, although occurring as a relatively early symptom in only 15 per cent and 20 per cent, respectively, of this particular group of cases, should make examination of the spinal fluid imperative. Lacking in any such intrinsic diagnostic value, but at least suggestive in view of its high numerical incidence as an early manifestation in more than half of the cases of this series, a history of irritability arising *de novo* should give sufficient ground for suspicion to demand the exclusion of general paralysis if the symptom cannot be accounted for with complete certainty on a more obvious basis. Similarly, even though somewhat less common as an initial symptom, a history of personality change such as has been above described as an apathetic or seclusive type of reaction should be regarded in the same light. Loss of weight, although

wholly undistinctive in itself, appears to be sufficiently characteristic of early general paralysis in many cases to suggest the possible presence of that disease in patients in whom other causes can be excluded. Finally, an increased tendency to sleep ranks almost with the first three symptoms just mentioned in both suggestiveness and incidence, and accordingly necessitates at least the keeping of the possibility of general paralysis in mind. The remaining symptoms—visual impairment, digestive disturbance, fatigability, insomnia, headache, tremor, rheumatoid pains—have, of course, no diagnostic value whatever; all that can be said of them is that they occur in some incipient cases of general paralysis and that they are consistent with the presence of that disorder. But just as the possible relationship of even minor gastro-intestinal symptoms to tabes has been repeatedly pointed out, so it is no less obvious that in the presence of this latter group of wholly ambiguous complaints it may become of only the greater importance at times to search elsewhere for their possible cause in neurosyphilis."

In the second paper, *Loss of Weight: Its Importance as an Early Symptom in General Paralysis,* Dr. Bunker gives a more detailed study of the 22 cases in which loss of weight was one of the earliest abnormalities noted and the 16 additional cases in the series in which loss of weight had definitely taken place, but later in the evolution of the disease. Twelve of these 38 cases had also a history of bulimia, or greatly increased appetite, which usually developed some time after the loss of weight had begun and which in a few cases counterbalanced to a considerable degree the preceding loss of weight. Seven additional cases had a definite history of bulimia, and while no loss of weight was reported, in several of them there was some presumptive evidence of such loss. It may be that loss of weight occurred in all of them, but escaped notice or was so fully counterbalanced by the increased food intake as to be imperceptible. The findings on these patients in the matter of response to treatment leads Dr. Bunker to make the tentative suggestion "that the behavior of the body weight in cases of early general paralysis may play a certain part in the response of the patient to subsequent treatment: while marked loss of weight during the evolution of the disease is not always or necessarily of poor omen for a satisfactory response to active therapy, a favorable influence in this regard may possibly inhere in the fact that little or no loss of weight has taken place or that the loss has been to a considerable extent offset by the increased food intake incident to bulimia".

The third paper, *The Significance of Gain in Weight in the Malaria Treatment of General Paralysis,* is based upon a study of the weight

curves of 62 patients under malaria treatment. Dr. Bunker summarizes the findings as follows:

"1. In a series of malaria-treated cases of general paralysis, a gain in weight above the pre-treatment level took place during the first three months subsequent to treatment in 80 per cent of the 62 patients. Such an advance was found in about 50 per cent of the mentally unimproved cases; but it occurred in 95 per cent of the patients who achieved full remissions, and of those who showed more moderate mental improvement.

"2. The increase in weight averaged 13.4 pounds (6.1 Kg.) at the end of six months, when the peak value was reached, an average advance of 10.3 per cent of the pre-treatment weight. At this time the 11 mentally unimproved patients averaged only 6.9 pounds (3.1 Kg.) more. The 33 improved patients, on the other hand, gained weight practically irrespective of the degree of mental improvement, the gain averaging 18.5 pounds (8.4 Kg.), an advance of 13.7 per cent of the pre-treatment weight.

"3. From the point of maximum gain at the end of six months, a certain tendency to decline was evident through the next six months. In the 33 patients followed for a year, this reduction was from an average gain of 13.9 pounds (6.3 Kg.) to 10.3 pounds (4.7 Kg.). For this decline the 'unimproved' cases were largely responsible.

"4. Failure to recover part or all of the weight lost during the actual course of the malarial infection seems definitely to be of unfavorable prognostic significance. On the other hand, a marked and rapid rise of the post-treatment weight curve above the pre-treatment level is often exactly coincident with well-marked mental improvement, and is of favorable prognosis up to a certain point; but this improvement is sometimes only temporary, and even in the presence of a maximum response from the standpoint of weight increase, a maximum result as regards the mental outcome may be prevented by the presence of other factors, such as organic damage beyond the possibility of functional restitution.

"5. The post-treatment gain in weight is probably more or less intimately connected with the mechanism of the malaria therapy itself as suggested by the facts that: (1) many patients exhibit it who show no mental improvement; (2) the maximum weight reached is not infrequently considerably in excess of the usual weight in health; (3) the maximum gain is often only temporary; and (4) a similar phenomenon has been observed in connection with foreign protein therapy of other types.

"6. The principal significance of the gain in weight here described consists in the suggestion of a fundamental alteration in the vital pro-

cesses of the organism (*Umstimmung*), which in some obscure way underlies the striking therapeutic results following malaria treatment."

Circulatory Ratings in Mentally Defective Adolescent Children: A Study of 100 Children. By Philip J. Trentzsch, M.D. *The American Journal of Psychiatry,* 5:593–603, April, 1926.

In a paper published a year or so ago[1] Dr. Trentzsch reported the results obtained by applying to a group of psychotic patients a neuro-circulatory rating test used during the World War as an aid in detecting unstable aviators. It was found that 82.61 per cent of the hebephrenic and catatonic types of dementia-praecox patients rated low and only 26.9 per cent of the paranoid types; also that only 11.2 per cent of the manic-depressive patients had low ratings. This is in line with the finding of other investigators that certain types of nervous and mental disease are characterized by a pathological condition of the cardio-vascular system. Lewis, for example, in a review of the material from some 4,800 necropsies performed at St. Elizabeths Hospital[2] reported that 71.55 per cent of the hebephrenic and catatonic types of dementia-praecox patients had small aplastic hearts, with incomplete development of the capillary system; and that 75.5 per cent of these patients had hearts of less than average weight as compared with 7.8 per cent of the cases of paranoid dementia praecox.

With the idea of developing a tangible method for the early recognition of this pathological condition, as a means of detecting the potentially psychotic individual, Dr. Trentzsch revised the circulatory test so that it could be applied to adolescent children between the ages of ten and fifteen. The revised test has been described in detail elsewhere.[3] It is briefly outlined in the present paper as follows:

"The heart rate and systolic blood pressure of the patient is taken on both standing and reclining. The patient next steps up and down on a chair, about 18 inches high, five times in 15 seconds, after which his pulse rate is immediately taken. The length of time it takes the pulse to return to normal is also noted. The results of each exercise are tabulated and scored according to given tables. A rating of ten

[1] "The Objective Findings in the Psychoses", by Philip J. Trentzsch, M.D. *Archives of Neurology and Psychiatry,* Vol. 12, pp. 370–79, October, 1924.

[2] *The Constitutional Factors in Dementia Praecox, with Particular Attention to the Circulatory System and to Some of the Endocrine Glands,* by Nolan D. C. Lewis, M.D. New York: Nervous and Mental Disease Publishing Company, 1923.

[3] "Determination of Possible Psychotic Trends in Adolescence by a Modified Circulatory Rating Test", by Philip J. Trentzsch. *Southern Medical Journal,* Vol. 18, pp. 258–63, April, 1925.

points or above is considered high or normal, while ratings below ten points are considered low. Eighteen points is the highest rating a patient can obtain."

This revised test was applied to 100 adolescent school children in a public school of the District of Columbia. They were all in the same grade, but had been divided into three classes according to their ratings on a psychological test. Twenty-six were in the advanced class, 45 in the middle class, and 29 in the retarded class. Four, or 15.3 per cent, of the advanced class, 4, or 8.9 per cent, of the middle, and 7, or 24.4 per cent, of the retarded rated below 10 on the revised circulatory test. The more or less stable middle class thus had the smallest percentage of pupils with a low rating.

When the principal of the school was shown the list of the 15 low-rate pupils, she stated that all of them were problem children; and their histories, as obtained from teachers and other pupils, showed many neurotic symptoms.

In the present paper, Dr. Trentzsch gives the results of applying the revised test to 100 adolescent feebleminded children in the Walter E. Fernald School at Waverley, Massachusetts. As a group these children rated high. There were only 2 with a rating below 10. One of these had an organic heart disease. Both were of the familial type of feebleminded, and neither was syphilitic.

In view of these various findings—the low ratings of the hebephrenic and catatonic dementia-praecox patients and of the public-school children with neurotic traits, and the high ratings of the feebleminded children—the test "seems a valuable instrument for detecting a certain type of individual".

Reducing the Cost of Syphilis in Industry. By William Alfred Sawyer, M.D., and Benjamin J. Slater, M.D. *The Journal of Industrial Hygiene,* 8: 317-321, August, 1926.

The authors give here a résumé of their experiences with syphilis among employees of the Eastman Kodak Company. During the three years, 1923–25, they took blood for Wassermanns from 3,447 individuals, of whom between 3.5 and 4 per cent gave positive reactions. Blood was taken in every case of accident, however trivial, and whenever possible in disease conditions, provided the patient made no objection. Objections, however, were rarely encountered. Taken in this way year after year, the total number of reactions secured has come to represent a survey of about 60 per cent of the older employees.

The 176 cases upon which the present article is based illustrate the practical advantages to industry of detecting and treating syphilis among employees, to say nothing of the benefit to the individual and

to society in general. In a number of instances, syphilis was found to be at the bottom of a condition which the employee attributed to his work: "A female employee struck the back of her hand against a machine; the injury did not yield to ordinary treatment, the pain continued for over one month, and the patient was dissatisfied. Another employee was struck with the handle of a truck in the left groin, which broke down, discharging pus, and there was general enlargement of other nodes besides those struck; the case dragged along for some time without a cure. Another employee fell, striking his knee; six months later he developed soreness, tenderness, and some swelling in the knee, conditions which he traced to the preceding fall, claiming compensation. A woman claimed that a furuncle in the groin was the result of a fall. Three employees complained of back injuries with prolonged residual pain. Nine employees had infections of the fingers, five of which were almost impossible to heal. Four workers claimed that their skin was being poisoned by conditions of their work; each had a macular eruption on the forehead and felt that it came from chemicals. There were four others who had leg ulcers, claiming injury by striking against objects. One employee believed that chemicals were causing him to lose his vision in one eye; in two months his vision had dropped from 20/20 to 20/200 in one eye.

"In every one of these twenty-five cases, the Wassermann was 4 plus, and antisyphilitic treatment cleared up the condition. The compensation aspect of the case was forgotten when a cure was effected. What the saving was financially is difficult to say, but we know that it must have been great when we consider that the award for one eye is $4,000. Certainly the protection which has been effected in every case more than compensates for the cost of this service. . . .

"To those industries which pay sick benefits as well as accident compensation, this work becomes of added interest. Ordinarily there is more money paid out in sick benefits than in accident compensation. It is here that our diagnosis is of assistance to the patient in securing proper treatment, and the company is saved a great deal in sick benefit.

"For example, one employee asked for a three months' sick leave, planning to change climate. This ordinarily would have been given with pay. The Wassermann reaction was found to be 4 plus. After treatment at a public clinic, the improvement was so marked that a sick leave was no longer thought necessary.

"One employee lost 517 hours during the first six months of 1924. After treatment, in the last six months of the year he lost 192 hours; and in 1925 he lost 50 hours. Another employee lost 203 hours in 1922 and 203 hours in 1923; after treatment, in 1924 he lost 12 hours; and in 1925 he lost 30 hours. Without treatment the tendency, of

course, would be to lose more and more time every year. The saving in sick benefits is obvious.

"Many other illustrations could be given of employees who were absent because of this disease. The list is so long that only classical examples may be cited. The value from the patients' point of view cannot, of course, be estimated in terms of dollars and cents. Such benefits must necessarily greatly exceed any financial considerations which may enter into a discussion of this series of cases."

Of the 176 cases, 49 were discovered through Wassermann reactions taken on their return to work after sickness; 28 on preliminary physical examination, of whom 6 never reported for work; 30 after accidents; and 69 in other ways. The cases included one primary lesion of the lip and 3 cases of secondary lesion; the rest were in the latent or tertiary state.

From the industrial point of view, the hardest symptom to handle was syphilitic asthenia. In many cases it was very difficult to persuade employees to take treatment. "Their whole attitude was characterized by a great indifference to everything. Promises made were frequently not kept. One man who had five children would sit by the fire entirely indifferent to the state of his family needs. There is no doubt that the spirochæta pallida takes away the energy of many workmen, and from being useful citizens they come to lead a vegetative type of existence which is incompatible with industrial efficiency. The whole picture of a syphilitic asthenia is that of an individual who is entirely insensitive to his own, to his family's, and to industrial needs."

One hundred and forty-five of the cases were men and 31 women. Ninety-seven of the men and 20 of the women were married.

"Of the married males, only five could be persuaded to bring their wives for a Wassermann test. Of these five, two were negative and three were positive. Curiously enough, the wives did not take enough interest to want to know whether they had the disease, for it is certain that most of them knew that their husbands were under treatment. Of the eleven unmarried women, one was married three days after the fourth dose of salvarsan. Treatment followed the nuptials, and she later gave birth to a healthy child."

One of the patients committed suicide, four became insane, and one died of uremia after a drinking spree.

Only 37 of the cases had had any previous treatment and only 9 were receiving treatment at the time when their condition was discovered by the authors.

"Every one of our employees who is known to have syphilis is now receiving treatment", the authors state. "We do not give such treatment at our dispensaries, but refer the individual to his own

physician, to a specialist, or to a clinic. There is a syphilis register, and each case is followed from year to year. Without this register, and without this follow-up treatment, who can say what these cases would have cost industry in complications if treatment had not been instituted?

"It is not our policy to discharge a man who has syphilis. If such were the case, it would soon become impossible to get the Wassermann reaction of anybody. There is the greatest effort at coöperation, and every encouragement and assistance is given the employee to get treatment as quickly as possible and at rates compatible with his financial condition. The public clinics in the city have proved a great help in this work.

"That the patient frequently does not realize the value of this type of service is shown by the fact that 18 employees quit within three months rather than submit to the follow-up; 6 others never reported for work at all. In other words, out of 176 cases, 24, or 13 per cent, preferred no treatment at all and left rather than be reminded that treatment was necessary. The turnover in syphilis is tremendous under the best of circumstances. One wonders what the future will be in eradicating this disease when such a large percentage will not take treatment at a price which hardly covers the cost of the medicine. Of those discovered, not over 15 per cent had previously received anything like adequate treatment or follow-up.

"If, however, all physicians in industry will tackle this problem earnestly, there is little doubt that great progress will be made. The Wassermann reaction will be popularized in the family as well as with the patient. More cases of syphilis will be taken care of; and may there not gradually develop a changed attitude on the part of employees in reporting the disease? Constant hammering will bring results. Industrial medicine offers an unusual opportunity to discover the disease, and, above all, the follow-up becomes relatively easy when the patient remains in the company's employment.

"In those communities in which there are no public clinics and no adequate facilities to adjust charges to the financial condition of the patient, it is the authors' feeling that a clinic could be established in the company at no great expense. The results, it is believed, would pay for any cost which would be attached to this type of service."

BOOK REVIEWS

PARENTHOOD AND THE NEWER PSYCHOLOGY. By Frank Howard Richardson, M.D. New York and London: G. P. Putnam's Sons, 1926. 200 p.

In an introduction of eleven pages this book states that its object is to acquaint parents with a few of the essentials of modern psychology as applied to the development and training of children. Its 200 pages of fine print are divided into twelve chapters, the titles of which catch the eye with their superlatives: *The Greatest Thing in the World—Love; The Greatest Danger in our Lives—Arrested Development; The Strangest Thing in the World—Our Consciousness; The Most Unreasonable Creature in the World—Man; The Most Potent Influence in Child Culture—Imitation;* and so forth.

The chapter on love acquaints the parent with the orderly development of childhood's "love life" through the stages of narcissism, parental fixation, homosexual striving, to a final heterosexual adjustment. The term "arrested development" does not refer, as would naturally be supposed, to stunting of the intellectual or physical growth, but to mismanagement of the emotional development, with resulting dangerous fixations. Fixations in the emotional life are caused by the child's "being denied the opportunity to live through an experience at the time that such an experience is normally to be expected", or by "overemphasis and prolongation of an emotional stage". For example, the child may develop a fixation "at the muscle-erotism stage" or during "the narcissistic period". The author here spends considerable time and energy in minute directions for parental guidance through these and similar intricacies tending toward "arrested development". The theme "our consciousness" is very simply handled, as to suppression, the daydream, and the subconscious mind, with the help of the immortal Dr. Jekyll and Mr. Hyde by way of illustration. Against the background of the first three chapters is a discussion of reason and emotion and imitation, which is concrete and to the point.

Home and Family and *Phantasy versus Reality* are chapters containing important facts of childhood mental hygiene that any parent would do well to read seriously. The eighth chapter deals with the general subject of education as it is carried on in the average school, with an honest presentation of the difficulties encountered, from the school's point of view and that of the home and community.

In discussing discipline, the writer covers 28 pages. The term discipline in his mind seems to be synonymous with corporal punishment and military commands, which the parent uses as an emotional outlet for bullying helpless offspring. He likens the parent's rationalizations of such procedures to the Prussianism of the late war. It would seem here that great issues of training have been confused with certain common abuses which no serious-minded parent or teacher attempts to defend. The real point is, How shall we instill into the child a few simple habits of behavior responses that will keep him socially well adjusted as he moves through life?

It is unfortunate that the facts contained in the chapters that deal with the subjects of sex and religion are so effusively expressed. The writer gives the impression of talking down to parents as he expects them to talk down to their children. The average American child of to-day, with all his modern sophistication, would not be held long by such an artistic revelation of mysteries.

In fact, the book is a curious mixture of certain ultra-modern psychological concepts of childhood development and old platitudinous attitudes of adult condescension to little folks, a combination that might result in the production of the beatific small person represented in silhouette upon the paper folder gotten out by the publishers.

Esther L. Richards.

John Hopkins University.

The Crisis in Psychology. By Hans Driesch. Princeton: Princeton University Press, 1925. 275 p.

This most recent work of Professor Hans Driesch, the well-known vitalist, who at present holds a chair in philosophy at Leipzig University, is addressed to "an interested general public" and deals with the subject of psychology in such a manner that, its author believes, "any person with a general education may follow it". The book is not a translation, but was written in English by Professor Driesch himself. The subject matter of the volume is based upon a number of lectures delivered in certain Chinese universities during the years 1922–1923.

In his preface, Professor Driesch informs the reader that for him psychology forms part of a general philosophical system, specifically filling a chapter of his *Ordnungslehre*. On the next page, however, he says that psychology is "the most promising and important of the sciences at the present time". This double standpoint is apparent throughout the work. In many places it is difficult to determine whether what is written is intended for metaphysical speculation or for scientific exposition.

The theme of the work begins with the enunciation of "the irreducible and inexplicable primordial fact: *I have something consciously,* or, in brief: I 'know' something, knowing at the same time *that* I know . . ." (Page 1.) From this basis, to which the writer refers continually throughout the volume, is developed a definition of psychology as "the theory of the variety of all the *somethings* which I may *consciously have,* and the laws which govern the sequences of these various *somethings* in time". (Page 2.)

Starting from this foundation, the author considers first normal psychology. Here he holds that what is consciously had must be analyzed by introspection into psychical elements. To what extent Professor Driesch believes that this "introspection" should be under scientific control is not indicated, in spite of the fact that we are given a section on "method" in which the psychological procedures of "behaviorism" and of the school of Külpe are adversely criticized. The six psychical elements which the writer's introspection discovers are as follows: (1) *The pure qualities or suchnesses,* such as "green" and "sweet". (2) *Data with regard to space and time.* "What is immediately present in many *somethings* is an accent of before (or after) . . ." (Page 14.) (3) *Pleasure and discomfort.* "They are not states of the Ego—but are objects to the Ego . . ." (Page 15.) (4) *The accents of order.* Here the reader is told, "We now come to the first topic of modern psychology which may fittingly be called revolutionary." In explanation, we learn that it is "the irreducible and indefinable *logical concepts* that here stand in question—the significance like *this, such, not, related, so many, because, whole and part, order.* I have all these meaning *as objects,* just as I have *green, sweet, pleasure, before.* Of course these significances are not 'sensible', not *'anschaulich'* . . . but, nevertheless, they are objects of my 'having'." (Pages 16 and following.) (5) *The accents of truth.* Thus a doctrine may carry with it the accent of being "true" or "wrong". (6) *The accents of existence.* These may be shown by the example, " 'Richard III' has one accent as the King of England studied in history, and another accent as a person in Shakespeare's play". (Page 21.)

The relationship between these elements, when they appear in such complexes as thoughts, feelings, and will, is next considered. In this connection the association theory is criticized at some length in a manner that is reminiscent in certain respects of the strictures against this theory urged by certain of the German "configurational" psychologists.[1] For Professor Driesch, the main failure of the association

[1] Cf., for example, *The Growth of Mind,* by K. Koffka. Translated by Robert Morris Ogden. Harcourt, Brace and Company, 1924. P. 245 and following.

theory is its inability to account for what he terms "limiting and directing agents". (Page 54.) In like manner, in the study of the phenomena of memory, "reproduction" is denied, and the assertion is made that what the associationist mistakes for "reproduction" is really "production", and that this is the basis of memory. The last topic considered in the portion of the book devoted to normal psychology is the "concept of my soul". This concept is held to be "my *immediate object,* but it is of the class of immediate objects which 'mean' mediate ones . . ." (Page 70.)

The second section of the work deals with psychophysics. "My body" is held to be "my *object,* . . . a something that is *consciously had* by 'I' ". (Page 89.) From the basis of this position both Weber's law and Johannes Muller's law of specific sense energy are given very brief consideration. Then follows a long argument upon the "body-mind" problem, in which, because of the presuppositions suggested above, both orthodox parallelism and interactionism are "refuted". We are told, in a manner that is veritably suggestive of Malebranche, that "*nature* and *mind* are two spheres of empirical existence which are absolutely separated from one another and, therefore, are absolutely unable to act upon one another in a causal way". (Pages 145 and following.) At this point Professor Driesch's vitalism asserts itself as a solution of this age-old question, and we are told: "Now there is, firstly, 'interaction' between the 'entelechy' *and* the matter of my body, and vice versa. This interaction occurs in the realm of nature, for 'entelechy' is a factor *in nature.* But, secondly, the *working* of the 'entelechy' of my body is 'parallel' to the working of 'my soul', certain *states* of which were parallel to 'my conscious havings'." (Pages 146 and following.) Again, we are told that "the brain + the soul = entelechy". (Page 148.)

In the few notes given upon mental disorders, the position is advocated that real insanity is "an 'illness' of the brain and not of the soul". (Page 149.)

The next two sections of the book are upon the metaphysics and the organization of mind. In the latter section the assertion of Brentano and Husserl that the conscious "act" may have different forms is denied. In place of this view, it is affirmed that "there is only one species of the genus *act,* namely, having . . ." (Page 166.) The soul itself is next discussed as a dynamic agent. This activity is divided into three sections: (1) The *inner dynamics* of the soul, which is the foundation of the inner mental life. (2) The *centripetal* dynamics of the soul, in which, "the body is affected by a physical stimulus; this then affects the parallel duplicity, *entelechy-soul,* and

this affection becomes conscious to the 'I-Ego' in the form of a perception''. (Page 174.) (3) The centrifugal dynamics of the soul, which is realized in action.

The remainder of the book is devoted to a consideration of such topics as the unconscious, dreams, hypnosis, hallucination, suggestion, dissociation, co-consciousness, telepathy, clairvoyance, prophecy, and the problems of freedom and immortality.

Thus is the ''crisis in psychology'' considered and the foundation stone laid for a new psychology, ''which will not be forced to pass through a *critical* state again, at least in the near future''. (Page 1.) All this in a book of less than three hundred pages, set in the large, clear type so characteristic of the Princeton University Press! The criticism of the work is obvious. A lifetime of grazing in the pastures of vitalistic philosophy is ill preparaton for an adequate consideration of the problems in so rapidly growing and complex a science as psychology. The system of psychology proposed as ''the new psychology'' by Professor Driesch is a rational psychology of the baldest sort, for unlike certain earlier non-experimental formulations, as, for example, that of Brentano, it disregards much previous valuable thought upon most of the questions considered. To take but a single instance, the doctrine of conscious elements, outlined above, is so far removed in its teaching from the established views upon the matter that it will probably never receive serious consideration.

Beside the long list of technical ''errata'' already added to the book by the publishers, there are many statements of fact throughout the work which are severely open to question. For example, we are told that modern normal psychology begins with Von Hartmann, James, and Bergson. (Page 4.) Again we read, ''The school of so-called *behaviorism* denies introspection. Also many behaviorists even go so far as to maintain that 'sensations' are the only objects of my consciously 'having'.'' (Page 9.) We should like Professor Driesch to tell us who these behaviorists are. The series, 1, 4, 9, 16 . . . is given (page 95), under the discussion of Weber's law, as the typical *geometrical* progression! Finally, in the consideration of various ''occult'' phenomena, which, of course, are almost universally avoided in the writings of contemporaneous psychologists, a most uncritical attitude is adopted. The statement is made, for example: ''In telepathy and mind reading, we find a direct dynamic relation between mind and mind *with no material intervention.*'' This, we are told, ''seems to prove that all mind is one at bottom''. (Page 236.) A surprising suggestion for a new social psychology!

To certain philosophers *The Crisis in Modern Psychology* may seem an interesting and significant development of the philosophy of vitalism. To the layman who goes to the work for information it

must certainly present a misleading picture of modern psychology. But to the professed psychologist who believes in the scientific method, no matter what his "school", the present work of Professor Driesch is likely to be of little interest save as an example of anachronistic thinking.

LEONARD CARMICHAEL.

Princeton University.

UNDERSTANDING OUR CHILDREN. By Frederick Pierce. New York: E. P. Dutton and Company, 1926. 198 p.

Among the many books that deal with child understanding and training is the latest work of Frederick Pierce. Written in simple, non-technical language, *Understanding Our Children* aims to disclose the unconscious mental processes of parents and children. The book is divided along chronological lines into the pre-natal periods, the mind pattern of the child, the development during early childhood —especially the development of unconscious factors—the pre-adolescent phase, adolescence, and the early mating period, and there is a concluding section on methods of mind management.

The volume has in it much to commend it to the lay reader, but also much that needs criticism and in some instances correction. Let us briefly run over the various sections. The first is an unnecessarily tedious account of the lack of understanding among many men and women of the responsibilities of parenthood, and the author's method of instruction in such cases. The second section starts off with an excellent description of the qualities most to be desired in individuals and groups and makes a very keen analysis of group or racial shortcomings. In fact, this is one of the best parts of the book, giving one a well-drawn picture of the sort of person one should strive to become. The dictum, "For the mind we want activity, elasticity, curiosity, imagination, construction, and fearlessness", is worthy of a place in the precepts of all education. There follows an account of some of the factors of inheritance. The author apparently holds that many of the qualities of "mind" are inherited, and while he qualifies this teaching by recourse to the expression, "inherent susceptibility", we are led to believe that many of our fears are rather inherited than acquired, a view that is open to controversy, if not to correction, in the light of some of the recent work on heredity. The pages of this section, devoted to instruction concerning the dangers of over-stimulation of tactile and auditory senses, are most timely and practical, as are those that appeal for a rational development and stabilization of the emotional life of the child.

The section entitled *The Early Childhood* deals with the child from

the second to the seventh years, and describes clearly and in a good deal of detail the formative factors of personality, vocation, and achievement. It discusses the emotional complexes of mother and father fixations and gives helpful suggestions concerning emotional guidance. One of the best things in this chapter is the appeal for good family team play. The word "play" brings to the reviewer's mind Mr. Pierce's ideas on supervised play. In no uncertain terms he decries too much supervision and organization in play and makes a plea for allowing children to use their own initiative, and thus to become self-reliant and resourceful like their pioneer forefathers.

Regarding discipline and punishment, the author wisely points out the need for studying the individual situation, for maintaining discipline once it has been undertaken, and for confining punishment to two types of offence—disobedience and lying to escape the consequences.

The next chapter deals with pre-adolescence and stresses the importance of school, "the nation's nursery", emphasizing the need for respect for the teacher as one of the prerequisites for the constructive school progress of our children. Glandular disorders are discussed, and a sane and conservative point of view on this important question is presented. In this chapter again very naturally we are instructed in the directing of the budding emotions, the emotions as displayed in "romance outside the family".

Up to this point the book has been simple and sensible, even if the frequent use of the term "we of the analytical school" has at times terrified us a bit, but now the author shatters the rule of reason by advising that we display graphs on the walls of our children's rooms showing "achievement wishes" and "self-centered wishes" and that we play the "interesting game" of charting this graph every night. Mr. Pierce has tried to deliver us from too much paternalism in our play, but now he would persuade us into having our children chart their wishes and so making inverts of our younger generation.

Section five introduces us to adolescence and the early mating period. Again the glandular dystrophies are mentioned and emphasized, and we cannot but feel that, with our extremely limited knowledge of treatment, we are here led to expect too much of glandular therapy as a panacea for our adolescent ills. Sex development and sex instruction are considered at some length and are discussed frankly and in accordance with our best teaching. The chapter is well summed up in the author's own words: "The best preparation we can give is teaching children to think clearly and independently."

The last chapter, *Methods of Mind Management,* is an exposition of the author's methods of utilizing suggestion and auto-suggestion. The chapter offers nothing new on this subject, but its application

to child training is stressed. A method of instructing the child as to the power of imagination is given in detail. This appears more applicable to laboratory experimentation than to the nursery or schoolroom and is not likely to be an efficient tool in the hands of many parents, or to appeal to the average child in his teens. Again, family team play is proposed as a vehicle for suggestion in the training of children, through discussions of mental life and growth in its various aspects by the parents within the hearing of the children.

Understanding Our Children understands them so well most of the time that we are all the more disappointed at its not infrequent excursions into the field of speculation and impractical theorizing.

Arthur H. Ruggles.

Butler Hospital.

Reluctantly Told. By Jane Hillyer. New York: The Macmillan Company, 1926. 205 p.

Seldom are we permitted to read a case history that is a medical masterpiece and yet an artistic achievement. In Jane Hillyer's work we have a mental illness described with clarity, vividness, and understanding. We see the beginnings, the progress of the mental disorder, the domination, the improvement, and the ultimate restoration to health.

The book should have a very wide reading. It is an important contribution to the understanding of reason dethroned and emotions disturbed, for both laity and the medical profession. Here the layman can learn how the foundations of the psychoses are laid and how the seeds grow into illness, and yet how a full degree of mental health can return; and the doctor, nurse, and social worker can gain a new understanding of the genesis of symptoms, the effect of environment, and the difficulties of convalescence.

Throughout the whole book the distortions of the mind are clearly and fearlessly unfolded in a descriptive narrative of tremendous human interest and true literary worth. We are brought face to face with the sense deceptions, the fears, and the delusions of a frank mental illness. Those of us who deal with diseases of the brain owe an especial tribute to the authoress for her thorough analysis of patient and environment, and we should have a better understanding of all phases of treatment from a reading of this remarkable book.

For the laymen *Reluctantly Told* should do much to dispel the mystery of "insanity" and demonstrate the curability of even prolonged illness of certain types.

Certain of Miss Hillyer's readers may be filled with regret that her treatment included the use of "strait-jackets" and that parole and

week-end visits home were not tried earlier, but they must remember that it is always easy for the bystander to tell how the game should not be played, but often hard to play it better than the experienced team is doing. Moreover, it is certainly seven years since the time of Miss Hillyer's narrative, and undoubtedly the hospital of which she writes has progressed, in common with the rest of us, beyond the use of mechanical restraint.

The story of the author's convalescence, during which hospital physician, psychologist, and New York specialist were called upon at appropriate times for guidance and help, is a splendid illustration of the mental hygiene of recovery and should be a lesson of caution to doctors and families who expect mental patients to make a successful transition from hospital to home without adequate supervision and assistance.

Reluctantly Told is the story of a mental sickness that actually occurred, no details are omitted, and sensitive souls may be shocked by some of the morbid incidents, but the story has long needed telling, has not been told in English since Clifford Beers wrote *A Mind That Found Itself,* and is here presented with calmness, unusual insight, and a skill that should command the attention of a multitude of readers and teach many valuable lessons.

Arthur H. Ruggles.

Butler Hospital.

Wilhelm Der Zweite. By Emil Ludwig. Berlin: Ernst Rowohlt, 1926. 481 p.

This book concerns itself neither with the Wilhelmian epoch nor the entire history of its leader, but is merely an attempt to portray Wilhelm II, ex-Emperor of Germany. And this from a psychological point of view. For the author attempts to trace the ex-monarch's traits of character, foreign policies, and autocratic behavior to physical inferiorities acquired at birth and to the family environment to which he was exposed.

Ludwig allows none of Wilhelm's enemies to speak, but sketches him from his own acts and from the reports and comments of his personal friends, who all give a remarkably uniform account of his mental traits. In this book we hear neither socialistic nor foreign speakers, only the Kaiser himself, his relatives and friends, his ministers, chancellor, generals, and other officials. We learn how a mentally gifted, physically weak youth, filled with the best intentions, but with a hard childhood behind him, was suddenly placed in a position of power and could find no one who would tell him the truth. With the combination of his physical inferiorities and his reaction to them, his

parents' attitude toward him, and the constant flattery to which he was exposed as kaiser, it is small wonder that he developed into the grandiose autocrat whose opinion and will were decisive in all the life problems of his country, in peace and war.

The book is divided into three parts, of which the first takes up the circumstances of his early life, the second his ascension to power and his conduct as emperor, and the third his behavior during the war.

We learn that his birth was a stormy one, not only for the mother, but also for the child. He was not expected to live. On the third day postpartum, it was noticed that the left arm was paralyzed, and the shoulder joint, with its surrounding musculature, badly injured. The left leg functioned poorly, and the left ear and side of the head pained the child. As he grew older, with his own effort and that of his tutor he tried to overcome these defects of nature. His tutor, Hinzpeter, writes: "Through an incurable weakness of the left arm, his mental and physical development suffered a very peculiar handicap which could not have been surmounted, with any amount of skill and patience, if the child had not assisted with unusual energy. It was a matter of overcoming a natural feeling of clumsiness and a feeling of timidity unavoidably associated with it."

He was brought up on what obviously for him was a false principle —to be every inch a king, to appear the snappy Prussian officer at the head of his regiment. With his physical defects, how could any child bear such training for a number of years without danger to his mental life? He was a pretty boy and somewhat girlish, shy, spiteful, and stubborn. His mother, Victoria, daughter of England's Queen Victoria, could never forgive a child who was incomplete, especially since she valued the blood of her husband less than that of her father. She harbored a secret reproach for him, and openly preferred her other children. No child will ever forgive such humiliation, especially when it is displayed before persons beneath his rank. Sometime the boy would seek revenge. His spiteful attitude increased his estrangement from his parents and helped to make him susceptible to political views opposed to their own. His mother in particular was liberal, and this had much to do with his later autocratic tendencies. The glamour of the Franco-Prussian War led him to feel that the history of his country was linked only with his immediate family and helped to bring the contrast, king and subjects, plainly before his mind. Unfortunately no one was there to hint that it all emanated from the brain of Bismarck and from a brave nation. His mother wished to send him to a civil school, as was customary in England, but Wilhelm, for spite, refused to attend, and the more liberal his parents wanted him to be, the more unapproachable he became.

On one occasion he was congratulated by his grandfather, Wil-

helm I, for the snappiness with which he led up his regiment. This moral victory over his physical weakness was his undoing. His physical weakness strove to emphasize physical strength instead of seeking strength in the mind, where his active intellect could have found it. Then, too, tradition and ambition drove him to prove his strength in a herolike military demeanor. "If this was the greatest day for the young prince, as he rode at the head of his regiment in the morning sun, to impress his father and grandfather, it was only a prelude to numerous other entries and appearances, clattering speeches, and threatening fists with which for decades he sought to legitimatize his feeling of self. He constantly oscillated between timidity and a feeling of self-importance, a youth who had to master a constant state of embarrassment." And so, later on, we always see him playing to the gallery, assuming the rôle of a hero, a Caesar. And was this form of compensation not to be expected in a man with his marked physical defects, which he always tried to hide and for which even his own mother had no sympathy?

At the manœuvers, he was ignored by his father, who openly showed a preference for Prince Henry, Wilhelm's brother. Whenever Wilhelm's father was ill-humored over the long reign of his own father, Wilhelm I, he would take it out on young Wilhelm. At a dinner, the young prince was insulted by his father before all the officers and guests present. On another occasion his mother said to an Austrian nobleman: "I cannot tell you how much I admire your handsome, brilliant, and elegant crown prince when I compare him with my uncouth, squarely built son, Wilhelm." And this made the rounds of all the courts of Europe. So deep was the unnatural aversion in the heart of the mother for her disfigured son. Ludwig believes that this attitude of his mother was the real factor behind his ambivalent attitude toward England. Time and time again he insulted England and the English, yet, for all that, his eyes were always upon her, studying her with a microscope, as it were, ready to imitate, and maintaining a constant state of envy toward her. In his attitude toward England and the enlargement of his fleet, Wilhelm was governed by his deepest feelings and instincts—the result of injury to his youthful pride. On one occasion he said: "Only my fleet gives me adequate recognition in England."

Toward Bismarck, Wilhelm never could have any profound inclinations, although as a youth, out of spite for his parents, he had a brief liking for the man of blood and iron. The typically Prussian temperament of Bismarck could not appeal to the young, Bourbon-like prince. When Wilhelm became Emperor of Germany, his egotism could not tolerate any dictation from Bismarck. And so, urged by Bismarck's enemies, his ill feeling toward the old chancellor increased

and ultimately led to Bismarck's resignation. The young monarch could not endure the humiliation of not being master in his own land, a rôle that he had always longed to play.

During the early part of the war, the Kaiser soon proved that he was incapable of being the hero he had always pretended to be; soon found himself unequal to the occasion, and was forced into the background and finally ignored. His cowardly tendencies had been known to a few even before the war. The old Junker von Köller once said to Hohenlohe: "May God preserve us from war as long as Wilhelm sits on the throne! He would lose his nerve, he is so cowardly!" Because he never wanted to admit the fear of a weaker person, he developed, from a character born to be on the defensive, an offensive attitude. Hence he always seemed to provoke the outer world, whereas he really feared it.

His temperament was typically syntonic, very labile, and tending to oscillate between depression and a buoyant mood of pomposity and vanity. He was sociable to the last degree, and could never tolerate being alone. His finger had to be in every pie, as it were. He was prone to sudden changes of policy and easily influenced. His vanity was unlimited, and he was perhaps the most photographed man in Germany—always in heroic poses. He was not romantic by nature and everything he did was cold and studied. Everything had to be organized. There was a tendency to be extravagant. At manœuvers he gave all sorts of orders, some of them contradictory, rushed back and forth, and constantly "showed off". At times he would say and do very excellent things, only to spoil it all with some tactless remark. The fastest airship and the strongest automobile held him more than the purple of a king's mantle. Nobody could ever convince him that he was wrong. He was fond of speech-making and traveling. To him princes were holy since God associated with them indirectly. And King Edward VII, his worst enemy, was for him more to be trusted than Roosevelt. He cared little for the company of women and preferred to surround himself with effeminate dilettantes—Count Phillip Eulenburg, for example, a confirmed homosexual and the Kaiser's close friend. Wilhelm was so theatrical that he could change his personality to suit every one he met. With the Czar, he was autocratic; with Cecil Rhodes, democratic; with Roosevelt, Americanized; and so on. And so, with few exceptions, people were charmed by him at the first meeting. He had broad interests, and a wide, but superficial knowledge. He was never a fighter, never dared open conflict, but would make little attacks from the flank. He was a peculiar combination of piracy, hegemony, crusadership, and grand historical theatricalism.

The book is instructive, highly interesting, and charmingly written.

The psychological and characterological mechanisms involved are well elaborated and delightfully presented. Ludwig does not delve into unconscious mechanisms, but gives a clever analysis of the dynamic factors involved in the Kaiser's psycho-biological reaction to his environment. I understand that the book will appear in English before long, and can warmly recommend it to those interested in character analysis.

O. H. Boltz.

Manhattan State Hospital.

Mental Abnormality and Deficiency. By Sidney L. Pressey and Luella Cole Pressey. New York: The Macmillan Company, 1926. 348 p.

To a certain extent the *bona fide* contractual relationship existing between every author and his reader has been violated in this most recent effort of the Presseys. The lay individual will find a bewildering array of blind alleys through which he will wander without profit; the clinician will seek in vain an adequately developed subject. In either instance the reader may well ask himself whether or not the demand upon his time has been justified. We are informed in the preface that the ensuing 312 pages have "attempted to formulate material for a college course which should give in vigorous, very direct, practical fashion acquaintance with the problems of mental health, mental disease, and deficiency". The authors, furthermore, have rather naïvely enumerated the scientific thews by which they are enabled to gird up their intellectual loins for this very estimable task. Those of us who care to hearken back to the peaceful time when *arma virumque cano* was scanned somewhat more frequently than it is to-day may recall that the land on which Dido so entertainingly beguiled the weary hours of Æneus was obtained by stratagem. Only so much land as could be enclosed by a hide was granted by the natives, but the wily Dido cut the hide into thin strips to include sufficient ground for the foundations of Carthage. By some such means, the Presseys have been able to stake out a land of promise with the attenuated bull hide of psychological precepts.

The book is divided into three sections—*Methods of Case Study, Types of Mental Disease and Disability,* and *Major Problems and Methods of Dealing with Them.*

In the section devoted to case study, methods of history taking are carefully considered under the usual subtopics relating to family and personal life. The developmental significance of the various lines of inquiry, however, does not seem to be sufficiently emphasized. The "present condition" of the individual is discussed from the physical,

intellectual, and emotional points of view. The authors suggest that the physician's examination may be eliminated in many cases, as the non-medical examiner can make this examination with the help of "a rough outline and some general directions". They believe, however, that the organic diseases require the services of a physician. This attitude toward the physical side of mental-health examinations is the battle-ground over which the sharp conflicts between psychiatrists and psychologists have raged for a number of years. The pros and cons of such a debate are beyond the province of this brief survey, but any thinking individual will admit the prevalence in mental cases of many physical disturbances obscure to the otherwise penetrating search of the non-medical observer. To ignore these symptoms is perhaps to invite complete failure in arriving at an adequate understanding of the case.

The intellectual aspects of case-work are handled with somewhat more assurance than the physical side of the problem through the topics of attention, judgment, memory, association, perception, and general intellectual level. In each instance brief consideration is given to the three possibilities of "over-functioning, under-functioning, or perversion of function". One wishes that the authors had used as much "gumption" in the remarks on the subject of physical findings as they have in considering the intellectual level. An instance is the following quotation: "The whole subject of intelligence tests and their use is evidently too special and also too complex and controversial for further discussion here." Yet many glib remarks are made in the preceding chapters on the significance of diminished knee jerks, negative Wassermanns, diabetes, and so forth. The side of case-history work that has to do with the emotional life is brought to the attention of the reader under the subtopics of general emotional tone, special emotional trends, and emotional conflicts. Brevity of discussion precludes any more thorough treatment of the subject than a few allusions to the obvious mental types belonging to these emotional states.

The chapter on the technique of case study has been skillfully handled. The investigator is warned against abruptness or carelessness in interviews, and the rather sage comment is made that "for understanding abnormal individuals not only intelligence, but imagination and some little emotional experience are necessary". Artificiality in manner or crude pushing for information are decried. The authors suggest concise, well-organized records and remark rather feelingly upon the ponderous, well-nigh useless mass of crude information to be found in the files of many hospitals. "Be specific, definite, and objective."

The second section of the book, *Types of Mental Disease and Disability,* gives careful consideration to the question, What constitutes normality? "The important thing to realize is that almost nothing is known of the families of the millions of individuals who are never brought to the attention of some investigator." The result of this lack of knowledge makes existing statistics on the subject almost worthless.

Under the caption "border-line conditions", neurasthenia, hysteria, and psychasthenia receive brief comment as types of emotional maladaptation. Apparently the authors prefer to associate psychasthenia with the compulsion and anxiety neuroses. No mention is made of the more recent contributions of the psychoanalytic school on conversion hysteria and compulsive and anxiety states. Emotionally unstable types are considered to be those "exhibiting constitutional anomalies of character", while the mentally peculiar are the "chronically unsuccessful". In this chapter on the psychoneuroses the enumeration of symptoms is concise and understandable within the self-imposed limitations of the book, but the subject of treatment is inadequate and the mechanisms involved scarcely receive mention.

The discussion of the functional psychoses is merely textbook descriptions of the symptoms of dementia praecox, manic-depressive insanity, paranoia, and related conditions. The authors avoid a consideration of sub-types of these psychoses by emphasizing the fact that "mixed forms" predominate and that "pure forms" exist rather in theory than in practice. The explanation offered for the brief space devoted to the functional psychoses is that the general investigator meets border-line cases rather than well-developed mental upsets.

In their consideration of the organic psychoses the authors seem to have encountered more snags than in the psychological portions of the book. They define "functional psychoses" as "essentially anomalies of character or development", and "organic psychoses" as "mental correlates of certain conditions of physical disease". In this manner physiological disturbances are confused with anatomical lesions of the nervous system. In accordance with this idea, the authors classify as organic the toxic psychoses, endocrinopathies, certain physical disorders accompanied by mental states—such as diabetes, cardiac disease, tuberculosis, and so forth—and the epilepsies. The question of epilepsy, of course, is still debatable ground, but few psychiatrists would care to lump the entire subject of epilepsy under an organic heading. The symptoms of paresis, the senile psychoses, and "gross brain disease" are outlined in classical textbook style without even an allusion to gross or histological pathology. Since "the conditions are rare", the endocrinopathies are dismissed with a brief and rather misleading three-quarter page on dysfunctions of the thyroid gland

and an allusion to the relation of the function of the gonads to dementia praecox.

The authors are on much firmer footing in their treatment of the subject of diagnosis, classification, and care of the feebleminded. Their grasp of many of the problems connected with the study of this large group of defectives is modern and effective.

The third section of the book, *Major Problems and Methods of Dealing with Them,* offers a number of suggestions on the differentiation between delinquency, economic incompetency, non-educability, and psychopathy. To a large extent the first portion is a recapitulation from another point of view of material dealt with in former chapters. Perhaps the most effective chapter in the entire book is the one on the extent of mental disease and disability, in which statistics of the second report of the Indiana Committee on Mental Defectives and a census of the mentally diseased in the United States made by The National Committee for Mental Hygiene in 1920 receive general application to the mental-health problems of to-day. The book closes with a brief review of the modern preventive methods used in mental-hygiene work.

In general the book is well-ordered and the style concise, the subjects follow one another logically, and each chapter is summarized, as well as illustrated by case citations. The bibliography and glossary composing the appendix are short, but well chosen.

It is not with the treatment of the material that the reviewer quarrels, but rather with the subject matter itself. The field covered is far too extensive to give the general reader more than a fleeting glance of the problems involved, and the discussion is too superficial to be of value to the clinician. In straddling the stools of professional reserve and popular appeal the authors have achieved a wide and somewhat precarious "split".

V. C. Branham.

New York State Commission for Mental Defectives.

The Young Delinquent. By Cyril Burt. London: D. Appleton and Company, 1925. 619 p.

The author is professor of education in the University of London, psychologist in the education department of the London City Council, and the author of *Mental and Scholastic Tests.* This book, the first of a projected series of three, deals with the child "whose failings are moral". The two books to follow will have to do with the backward and the nervous child. The author in this first volume aims to explain the causes of delinquency and ways of treating it. The book

is written for the interested parent, teacher, and social worker—for the busy reader. The size of the volume, however, will be apt to frighten away the very people for whom it is intended.

For convenience of classification and study of children "whose minds are subnormal", Dr. Burt utilizes the old tripartite division of the mind—*i.e.*, intelligence, emotion, and character or morality—and in accordance with this division recognizes three types of "subnormal" children—the backward, the unstable, and the delinquent. He looks upon delinquency as a weakness in the moral life alone of the child, and indicates that subnormal intelligence and subnormal emotion make for some other type of abnormal reaction quite distinct and apart from delinquency. Then, in defining character or the moral side of the child, the author includes "all those qualities of the mind which do not constitute or are not pervaded by intelligence"—obviously the instinctive and emotional phases of the individual.

One would think, from the preface and from statements in other parts of the book, that defects in the intellectual and physical fields are not important in the development of delinquency or at least are quite secondary to the so-called moral defect. But one finds that the author takes no such narrow point of view in the actual study of his cases. This study is most comprehensive, including careful investigations of family history, developmental conditions, environment, school and employment records, personality development, and the like; careful tests for verbal and non-verbal performance, for reasoning, and for specific abilities and disabilities; a psychiatric examination with careful attention to the child's own story; and finally an analysis of the entire situation and a working out of probable etiological factors, with suggestions for treatment based on causation. Not only are findings of the entire histories and examinations of many cases found in the footnotes, but abstracts of these cases, written most interestingly in a narrative form, are introduced into the text. In the sections in which the author discusses character—Chapters IX and X and part of XI—he has turned away from his studies to the reflections of other writers, and the result is that he becomes less convincing and at times apparently contradictory. Had he merely presented the cases and the conclusions that could be safely drawn from the studies, without attempting to offer a proof of, or to hitch up these findings to, an academic psychology evolved without clinical observation, his book would have a greater value to the practical workers for whom he has written.

In a summary of 14 pages the author points out the fact of multiple determination in the causation of crime: "Crime is assignable to no single universal source, nor yet to two or three; it springs from a wide variety, and usually from a multiplicity of alternative and converging

influences . . . The nature of these factors and of their varying combinations differs greatly from one individual to another . . . Hitherto the fund of possible explanations invoked by the criminologist has been much too narrow . . . Drink, epilepsy, heredity, or some common characteristic of a city life is seized upon in isolation and made accountable for all. With the same exclusive emphasis some solitary panacea has been correspondingly put forward. . . . Crime is the outcome of many confluents."

In the author's 197 cases, he found 170 distinct conditions contributing to the childish misconduct. He condenses these into fifteen major factors ranging in the order of their importance from defective discipline, through general emotional instability, intellectual disabilities, defective family relationships, to poverty and physical weakness or infirmity as the determinants of least weight. The within-the-home influences, such as inconsistent, vacillating discipline, parental examples, and the child's relationships with the parents, are very important. Mental dullness not severe enough to be called deficiency, and temperamental instability not sufficiently abnormal to be called pathological, are seen with great frequency among the delinquents.

Statistics relative to types of offense, hereditary conditions, environmental factors, developmental and physical conditions, disease manifestations, intelligence, and educational attainments of the group studied are worked out with various intercorrelations and are compared with a small control group. The author's cases were drawn largely from the poorer sections of London.

In his discussion of treatment, the author gives various procedures that have been evolved through the actual handling of cases, and these should prove of value to the parent and the teacher. Yet treatment, the author frankly acknowledges, is largely in the trial-and-error stage. Lastly, there is a word relative to the results obtained through treatment: "Among the group in which the essential recommendations were carried out, in 62 per cent an apparent cure has resulted"—that is, no delinquency has been reported for at least one year; in 38 per cent progress was made. Where the treatment advised was not adopted, 12 per cent underwent a spontaneous and complete cure; 23 per cent made some progress.

The writer deduces, from his ten-year study, six principles for the prevention of crime and for the reclamation of the delinquent individual. These are:

1. Treatment of delinquent tendencies should begin at the earliest possible stage. This involves the identification of school children who show any deviation from the normal. The author emphasizes particularly the pre-school and adolescent epochs.

2. The problem of delinquency should be an inseparable part of a general child-welfare program. Every worker with children in schools, bureaus, or courts should familiarize himself with this problem and assist in its solution in his handling of unadjusted children.

3. *Individual* study and treatment of the delinquent child in the environmental, physical, and mental fields are necessary.

4. Treatment remedies must be based, not upon the nature of the offense, but upon the nature of the factors that provoked it.

5. More knowledge regarding both the causation and the treatment of crime and delinquency is needed.

6. There is need for an investigation and a modification of present housing and industrial conditions and educational methods; also for increased facilities for recreation, and better medical treatment of children.

The discussion of environmental conditions (Chapters III and IV) and of intellectual conditions, especially subnormal intelligence (Chapter VII), and the concluding chapter, were perhaps the most interesting to the reviewer.

R. R. Williams.

Memphis Child Guidance Clinic.

Genius and Disaster; Studies in Drugs and Genius. By Jeannette Marks. New York: The Adelphi Company, 1925. 185 p.

Jeannette Marks' book is the fruit of much sincere and painstaking study and made of the stuff that will provoke unlimited discussion. Because her researches take place in an age that is waging the first determined, intelligent fight against the unlicensed use of alcohol and drugs, the reader, whether agreeing or disagreeing with her, will find her probings curiously alive. They deal with poets, those singularly sensitized beings, so often the outcasts of the world, whose brightly painted, lurid mental flashes resemble the flight of a rare comet and who cannot be judged by ordinary standards. In a close and delicate appreciation—and dissection—of Poe, James Thomson, Swinburne, and Francis Thompson, with special mention of Coleridge and Rossetti, she enlarges her theory that opium and alcohol play a notable part in the peculiarly morbid quality of their creative genius. She says: "In individual cases, which *does* add more to the energy of the community, genius with some of its roots embedded in disease, or perfect health without the genius? A dark problem and a bitter battle-ground!" But with all our boasted and growing power of psychoanalysis, have we arrived at the place where we can estimate what strange intermingling of molecules and microbes makes up that elusive quantity we term genius, and whether it would not always take its course uninfluenced by outward stimuli or inward heartbreak?

Whether Miss Marks' premises are correct or far-fetched, however, the development of her theory is brilliant. According to her: "The pictures drawn by the alcoholic are sharp and distinct. Take the sharpness of the pictures in *The City of Dreadful Night.* Dürer's *Melancholia* is not more distinct. Compare the dark solemnity and weight of *City of Dreadful Night,* with its pictures bitten in as if by acid on metal, with the strange gaiety and luminous phantasmagoria of Coleridge's *Kubla Khan* . . . The very 'heft' of the two poems will tell quickly which is alcohol and which is opium: the structure of alcohol in writing always weighs heavier than opium. The purple patches of alcohol are unmistakable." She speaks of "the opium stigmata" in *Kubla Khan*—"the alternate shiftings and drag of attack".

These statements must be left to scientists to prove or disprove. To leave discussion aside, the book as a series of poetical portraits has marked distinction. The author handles her material without a trace of academic dryness and in a poetic and fortunate manner. Of Poe we are told: "Something a little dry like light . . . there was always in Poe's genius. His was a nature chill in places, white hot in others." And of James Thomson, who, in the midst of sentimental imitations, produced *The City of Dreadful Night:* "He can scarcely be said to create. The creative faculty is something deeper than the executive: it is slow of growth, stamped with originality, marked often by inequalities." Of Swinburne she makes the discerning remark: "His dilutions are immense. Here is accomplished fluidity . . . the mill-stream idea of poetry ceases to bring with it even the sweet sound of falling water or the peace of droning bees."

But as we turn away from the book, it is with the feeling that Poe would have written *The Raven* in its present form had he never touched either opium or alcohol. Genius resides after all in the inherent fact of personality, stronger than any outside influence that can be brought to bear upon it. At least so thinks the reviewer, who may be as wrong as wrong.

Laura Benét.

New York City.

The Psychology of Vocational Adjustment. By Harry Dexter Kitson. Philadelphia: J. B. Lippincott Company, 1925. 273 p.

This comprehensive, discriminating survey of the entire field of vocational adjustment points out clearly the problems involved, records and evaluates the methods that have been employed as aids in vocational adjustment, and definitely establishes the principles of scientific procedure in this field. The author constantly envisages the future by determining the exact status of the present knowledge

of vocational adjustment at every turn, by indicating the territory as yet unexplored, and by suggesting and illustrating various methods of applying the knowledge at hand.

A history of the origins of vocational psychology is presented, with an account of the development of the vocational-guidance movement in this country and abroad. The attempts, both scientific and unscientific, to solve problems of vocational adjustment are described, and one chapter is devoted to the claims of phrenology and character analysis and the evidence of their unreliability. In considering the signs of vocational maladjustment, the author formulates rules for developing interests and follows with a discussion of the problems involved in labor turnover, considering its costs, causes, and methods of measurement. A study of the vocational changes of one thousand individuals in *Who's Who* reveals the incidence of such changes and their relation to education and age at time of change.

The greater part of the volume is devoted to methods of vocational analysis. The use of scientific, objective measurements is stressed throughout. But the author's conception of scientific measurements is not confined to the application of tests. Indeed, he states, "The most economical thing to do is to lessen the emphasis on tests, at least temporarily, and place more emphasis on the scientific analysis of vocations until it has reached a stage of refinement equal to that of the tests." And again, "One who would be bold enough to defy conventions might suggest further that perhaps it will turn out that tests are not the best tools to use, after all." In vocational analysis, one criterion is rigidly adhered to—namely, that the vocation and the worker cannot be divorced; and the central thesis of the author's four principles of scientific analysis is that it must be made in terms of the worker at work.

The chapter on intelligence as a factor in vocational adjustment is prefaced with a rather exhaustive discussion of the definition of intelligence and the limitations of intelligence tests. In their application to vocations, the author deplores the unwise use of the method of correlation and advocates the use of a probability curve as more serviceable. Special abilities and aptitudes are accounted for not on the ground of innateness, but as the possible results of "some physical, non-neural impediment to certain types of adjustment" or of early emotional experiences which either arouse or dampen interest. Trade tests for measuring these aptitudes are discussed and their procedure is formulated. Seashore's musical-abilities tests are cited as ideal.

Emotional and interest factors in vocational adjustment have not been objectively analyzed. The use of the galvanometer is listed as an objective method for measuring interest, but the objections to it are many. Psychoanalytic concepts are also briefly mentioned, and the

author touches on such motives in the selection of vocations as arise out of a desire to surpass the father or a feeling of inferiority. The guarded conclusion as to these concepts is, "Though we may not subscribe wholeheartedly to such explanations, we must recognize that among the multifarious motives leading one to be interested even superficially in one occupation rather than in another, there are probably some factors of this hidden sort, and though we need not accept them in their entirety, still we may properly admit that with certain persons they may conceivably operate, and that the psychoanalytic method may sometimes give light." One type of emotional instability, the paranoid personality, is mentioned, and mention is also made of the need for psychiatrists in industry to assist in "the solution of grievance problems" and in "job selecting for certain psychopathic or cranky or 'different' employees, whom it would be extremely desirable to retain in service".

An excellent scientific study of the limits of industrial incentive as measured by the output of forty experienced hand compositors is presented, and on the basis of this the author revises a current conception that premium incentives and other speeding-up devices are wrong because they bring increased output at the expense of the workers' health: "Instead, it may be a beneficent device that leads the worker to produce more by eliminating wasteful movements and substituting time- and effort-saving movements . . ." An industrial incentive should be regarded as a concrete thing rather than an abstract entity and should be defined in exact terms, and its results must be measured in quantitative terms.

There is a chapter on records as aids in vocational adjustment, and another contains a critical estimate of rating scales. In a chapter entitled *A Tenable Conception of Vocational Fitness,* the author denies that an individual is in any sense born for his job, and sets up the thesis that one may successfully adjust to several vocations. Vocational guidance cannot aspire to prophesy success for the individual in any given occupation, but must rely on statements of probability. Finally, the author's philosophy concerning vocational adjustment is: "The greatest service which science can render is not to select a vocational field for an individual nor to select workers for an employer, dramatic and desirable as the undertakings appear. Science will render its best service in furthering the interests of the individual while he is at work; in helping him to perform his work more efficiently; to become deeply interested in it; to see the future possibilities in it; to prepare himself for them; and to realize them."

E. K. Wickman.

The National Committee for Mental Hygiene,
Child Guidance Demonstration Clinic No. 2.

EDUCATIONAL AND VOCATIONAL GUIDANCE: A CONSIDERATION OF GUIDANCE AS IT RELATES TO ALL OF THE ESSENTIAL ACTIVITIES OF LIFE. By William Martin Proctor. Boston: Houghton Mifflin Company, 1925. 352 p.

The reviewer agrees with the author and with Professor Cubberley, editor of the Riverside Textbooks in Education, that this is a helpful book for those who are interested in guiding youth. It is the second contribution in this field by the author, the first having appeared in a monograph series under the title, *Psychological Tests and Guidance of High-School Pupils*. In the present volume Professor Proctor emphasizes the reorganization of elementary and secondary education. There is a real need for the organization and early functioning of the guidance movement, in view of the haphazard, costly, and wasteful methods now in use. Various workers have shown that present methods of teaching and administration fail to meet the "life needs" of from 40 to 60 per cent of the children in enrollment. To assist in conserving human material, eliminating its waste, and improving its efficiency, the school counselor or "social engineer" in education must have the active coöperation of guidance-trained teachers. There should be, of course, in the school system, other workers with intermediate degrees of training who would assist a bureau of research and guidance in the application of tests and in holding interviews. Professor Proctor shows how the educational- and vocational-guidance movement might operate in different communities. He also shows that revised curricula, improved methods of teaching, and scientific grading are necessary changes for the future progress of guidance. His statements of aims and plans are concerned not only with the development of the movement, but also with the correction of existing defects. His method of treating the subject is to discuss general principles and to describe current practices. At the end of each chapter, there are a number of useful questions and problems to be solved by the student, together with a list of selected references.

Although Professor Proctor has made his subtitle somewhat ambitious, he has included under the guidance movement a more than usually complete account of the aims of education as a preparation for a well-rounded, useful life. Though still in its infancy, guidance has passed from the stage of philosophical speculation to that of experimentation. It is not so many years ago that there were no organized facilities for assisting one to decide upon and plot out one's life's work. Many people were either misguided or floundered miserably from the kindergarten to the graduate school at the university. Educational science to-day is showing more interest in the individual and is persuading the schools to do likewise, especially

through educational and vocational guidance. Guidance involves, first, the discovering and training of capacities and, second, the creating of character and the inspiring of effort. It is a continuous process, to be carried on over a number of years. The important thing about guidance in the elementary grades is to see that the rate of progress is suited to the child's individual needs and capacities, with the object of training him "in the habit of success and not of failure". The ultimate aim of guidance is self-guidance, assisting the child to find himself, through motivation and integration of education. These are high goals. And yet Professor Proctor has not overdone his subject, nor written it in the vein of a best seller, as other writers in this field have done before him. Neither does he lead us to believe that the last word has been said or that there is a royal road to guidance. He brings up the doubtful points, warning us against dogmatism with regard to personality traits, on the one hand, and over-enthusiasm in counseling on the other. The place of tests in educational and vocational guidance is fully discussed, and the function of the school and other social and professional agencies is taken up. The wide range of intelligence within a vocation limits the value of present intelligence tests for vocational guidance. After a broad experience, the author is cautious in his attitude toward tests and mental testers, and urges care in the interpretation of the meaning and application of the test results. The neglect of factors other than intelligence is another pitfall. "Care should be taken to avoid attaching too much importance to the idea of a permanent choice of occupation during the elementary and high-school phases of education." Then Professor Proctor gives a number of principles to cover the gathering and use of such data. Guidance in the selection of an avocation is in many respects more important than guidance in and training for a vocation. For an avocation can be turned to as a shock absorber of disappointments in occupational reverses.

That the guidance movement is closely related to that of mental hygiene may be seen from the headings of a number of the chapters in Professor Proctor's book: *Exploration of Special Interests and Abilities, Guidance through Provisions Made for Individual Differences, Guidance in Social and Civic Activities, Guidance in Health and Physical Activities,* and so forth. But it is to be regretted that Professor Proctor has neglected his treatment of mental hygiene. The only references to the literature are to the two studies of Hoag and Terman which were published in 1914. There is no mention of Professor Burnham's valuable book on the normal mind, nor of any of the important researches from mental-hygiene clinics and from special departments in colleges. The author states that the "drop-outs" are most in need of counseling and guidance in choosing an

initial vocation, and, as he knows, a considerable proportion of them will perhaps require some readjustment in personality and physical make-up. And it is just these individuals that the social worker, the visiting teacher, the clinical psychologist, the psychiatrist, and the medical examiner are trained to assist. None of the specialists receives mention. The rôle that they might play in coöperating with a bureau of research and guidance and with a school guidance clinic is not touched upon. The difficult children in school, presenting abnormalities in heredity and environmental influences, should be of interest not only to the educator, but also to the research worker, for the light that they throw on normal adjustments. Professor Proctor has perhaps expected too much from counselors and teachers. The making and maintaining of a "close contact with the pupil's parents or guardians" requires more time and ability than are usually available. Yet rarely can first-hand knowledge of the home be dispensed with. Changing undesirable habits and attitudes in children and parents is so difficult as often to require the skill of experts. Workers in the field of guidance and mental hygiene should be of help to one another.

Professor Proctor believes that the guidance movement will be handicapped as long as normal schools and colleges are not prepared to offer courses in educational and vocational guidance. He has truly helped it along by giving the distinctive features of the most important school guidance bureaus in the United States. The guidance work of other countries is strangely not referred to.

The administrative aspects of guidance are presented with extensive knowledge. The brief treatment of the actual technique of guidance will be sadly missed by the student and worker who is interested. Professor Proctor states that the interview is one of the most important methods in guidance, but he gives us very little information about it and no reference is made to its psychological literature. Counselors can learn a great deal from the skillful manner in which psychiatrists conduct the interview with problem children. Even though "inquisition" methods are avoided, and "informality", a "spirit of sympathy and genuine interest", prevail, I am compelled to disagree with the plan of having the pupil appear in person for examination before the assembled clinic staff. The best practice in mental-hygiene clinics disapproves of this, both because of the disturbances that it is apt to arouse in problem children and the administrative difficulties involved.

The preparation of a book on educational and vocational guidance is particularly difficult at this time. It cannot but contain matters open to criticism, and it is the duty of the reviewer to notice these.

We are, however, grateful to Professor Proctor for the accurate and clear presentation of the latest facts and aims of this growing subject.

Richard H. Paynter, Jr.

The National Committee for Mental Hygiene,
Child Guidance Demonstration Clinic No. 1.

The Healing Gods of Ancient Civilizations. By Walter Addison Jayne, M.D. New Haven: Yale University Press, 1925. 569 p.

This volume is the second work published by the Yale University Press on the Philip Hamilton McMillan Memorial Publication Fund. While intended only as an introductory historical study of the ancient methods of religious healing and the pagan healing gods, it is a most painstaking compilation of materials culled from many sources hitherto little treated by writers of English. The author has selected for study several of those great civilizations that preceded and overlapped the Christian era, from the beginning of history up to the time when the Emperor Theodosius suppressed paganism. Among these nations religion and healing had passed beyond the elementary stages of development and were more or less systematized under priesthoods. Their healing customs and the beliefs that prompted them were representative of their age and illustrate the ancient relations existing between religion and the healing art which were continued under the Christian fathers in a more or less modified form.

Those who are accustomed to look upon religious healing cults as comparatively modern developments will find ample evidence in this book that there is indeed nothing new under the sun. One is led to pause and consider what the meaning of this persistence of the religious idea in relation to healing may mean for the healing art.

The writer approaches the subject from a strictly historical standpoint, avoiding all theories and controversial matters as much as possible. He has gathered facts, traditions, and myths from archeological studies, the works of classical authors, and the treatises of authoritative commentators. The subject matter of each nationality is considered independently and under two sections: first, a general review of the salient features of their respective religious and healing customs; second, the personalities of their deities most intimately concerned in the cure of the sick. Owing chiefly to the imperfect and fragmentary character of the ancient records, no pretense is made to completeness, especially in the lists of the healing gods. The reader will, however, find a wealth of fascinating material packed into these pages.

Ancient Egypt, Babylonia, and Assyria, the pagan Semites of the

West, ancient India, ancient Iran, ancient Greece, ancient Rome, and the ancient Celts are the nationalities included in the study.

The book has as a frontispiece a reproduction of the head of Asklepios of Melos and there are six other reproductions from various sources by way of illustration of the text.

An extensive bibliography adds to the value of the contribution, and the careful index facilitates access to the contents of the book, so that it may readily be resorted to for reference purposes as well as for entertaining and instructive reading decidedly above the ordinary.

Alice E. Paulsen.

New York City.

Speech Correction. By Richard C. Borden and Alvin C. Busse. New York: F. S. Crofts and Company, 1925. 295 p.

This book is well bound, well printed, and adequately and well diagramed. The paper, margins, and make-up in general predispose the reader to a friendly attitude. The material of the book is presented from the point of view of the practical worker in speech correction, with especial stress on the correction of a foreign accent.

The first forty pages are devoted to a description of the mechanisms of speech. They are followed by eighty pages of matter illustrating and describing the sounds of spoken English. The remainder of the book is given up to a discussion of the defects of speech, the technique of diagnosis, and very admirable reading blanks and outline.

The phonetic studies in the book are sound and conservative, although some objection might be raised to the omission of "final l" and of "voiceless y", especially as the former is a constant source of difficulty in dialectic speech. The emission also of the standard diphthongs is to be regretted, as these five sound combinations cause great difficulty for a majority of the Afro-American population. The omission of the now standard diphthongs spelled with "r" is also to be regretted since it is with this sound combination that the Middle- and Far-West dialect is most concerned.

The speech defects are classified as: (1) organic; (2) defects of foreign dialect; (3) defects of provincial dialect; (4) defects of carelessness; (5) defects of infantile perseveration; (6) neurotic defects.

The section on foreign dialects is very good indeed. Workers with German, French, Hebrew, Spanish, Norwegian, Danish, Roumanian, Hungarian, Greek, Chinese, Czecho-Slovakian, or Jugo-Slavian will find this section of great interest, as will also those interested in comparative phonetics. Of great interest, also, are the rules for English pronunciation from spelling given on pages 197, 198, and 199, inclusive.

There are some errors in the authors' study of provincial dialect, the pronunciation "dreamt" is condemned as the past tense of "dreamed", although it is given as standard by Jones. "Sassy" is classed as a mispronunciation of "saucy", whereas the source of the word "sassy" is from the African languages. It is a term used by Negroes in the South, and means "mean, tough Negro". They object, also, to "gunnel" for "gunwale", although "gunnel" is standard and the only pronunciation given in Jones. Likewise, objection is made to "fo" for "four", "Havad" for "Harvard"—which are also standard.

In the discussion of defects of carelessness and of organic defects, the authors are quite sound and constructive. They go into some detail in regard to medical and surgical procedures, with much sound advice as to reëducation.

In the discussion of the two remaining types, they are not so satisfactory. The first rule given for the treatment of infantile perseveration is, "Make the patient thoroughly ashamed of his defect." This procedure in nervous, sensitive children might give rise to a stutter.

Chapter X, on neurotic defects, is very brief, the authors specifically claiming no authority in that field. They do, however, unreservedly recommend psychoanalysis—a procedure suitable to only a limited number of stutterers and stammerers for two reasons: first, to obtain the best results, treatment for this disorder should be begun when the difficulty begins, usually in the second or third year, a period for which there is as yet no adequate analytical technique; and second, among those who do not come for treatment until later, a very large percentage are what is classed as "unanalysable" until a long period of what might be termed "situational analysis" has modified the severity of their emotional disturbance. For all, including those who are suited to analysis, there should be, in addition, carefully selected and supervised opportunity for practice in the development of poise and ease in social situations. It should be said in passing that in disorders of speech with a presumably psychogenic origin, it is well to omit a "speech" examination, as the suggestion so subtly given greatly retards the work of the analyst. Where two or more speech defects are encountered in the same individual, the "neurotic defect" should be given right of way.

This book should be a distinct help to all those interested in speech disorders, especially to those who have to deal with disorders of articulation. It is sound and instructive and can be unqualifiedly recommended to those working in the field of speech correction.

Margaret Gray Blanton.
Smiley Blanton.

Child Guidance Clinic, Minneapolis.

THE PSYCHOLOGY OF THE PRE-SCHOOL CHILD. By Bird T. Baldwin and Lorle I. Stecher. New York: D. Appleton and Company, 1925. 265 p.

On the cover of this book is printed the statement: "This book is a guide for all who are in any way responsible for the training of a little child, giving as it does a scientifically sound program for the development of the child between the ages of two and six years. It gives a clear insight into the physical, mental, and social growth of a group of normal and superior children, studied by the authors in the Pre-school Laboratories of the Iowa Child Welfare Research Station. The fruitful results of these observations and experiments offer the means of directing the child's development so that he may successfully adjust himself to life."

In the preface of the book (pages V and VI) the authors make the following statement: "Every year hundreds of maladjusted children are brought to clinics where specialists advise how to correct their behavior in order that they may live more in harmony with their environment. The present scientific study of the pre-school child, in contrast to the former reliance on correction, aims to find out the best conditions for his development rather than the best methods of reconstruction after the results of misbehavior have become lasting."

These statements, coupled with the title of the book, indicate a goal that we all desire and lead one to expect new methods and technique and results heretofore unpublished to help us in solving the problems of the pre-school child.

The first chapter gives an account of previous work with the pre-school child principally from the angle of psychology. There is also a historical sketch of experimental studies and treatises on the subject. Psychoanalysis is noted in eight lines, and Woolley and Thom are the latest authorities quoted on this subject.

Chapter II covers the physical growth of the child and includes detailed instructions for making physical measurements. Norms are given for age, height, and weight. Tables, diagrams, and photographs are used freely not only in this chapter, but throughout the book. It is found that the physical growth of boys in general is greater than that of girls except for the greater growth and development of those characteristics typical of female development. Girls, however, attain greater development in stature for age and sex; also ossification and physiological development are more advanced, although girls show more variability in physical growth than boys in the majority of traits studied. Physical growth in children is largely individual, according to the authors.

Chapters III to VI, about one-half of the book, are devoted to a

consideration, in terms of psychological tests, of the various phases of intellectual development. It is acknowledged by the authors that they are working with a superior group of children from the better social level. The children's I.Q.'s improved with additional testing practice, contact with the school environment, and so forth, and a fair conclusion is that young children benefit by such opportunity for mental growth as is afforded in the laboratory. All experiments are described as made under observation, and notes of method and discussions of the group findings are given under each study. Some of the psychological tests used are recommended for use with certain ages; in the use of others further standardization and experimental application to younger or older groups are suggested. These descriptions are very good and the occasional notes on the accomplishment of individual children are excellent. Two-year-olds were rarely tested or scored low, when tested, because of the unsuitable tests for this age group. Fatigue and confusion were common, so that younger children could not keep the task in mind. In addition to tests for I.Q.'s, experiments were carried on for motor control, coördination, perception, association, language, æsthetics, rhythm, design, proportion, and concepts of weight, number, and time. As would be expected, the chapters on mental development, which deal largely with psychological testing, are the best in the book.

The rôle of practice, sex, and the relation of physical to mental traits are recorded in Chapter VIII. The children profited by practice. Girls were best on the Montessori frames, but the boys did better with almost all other work and a slight positive relationship was found between height, weight, and mental age. There was apparently no relationship between mental age and ossification. The daily program and equipment used in the laboratory are detailed in Chapter IX. The children are divided into three age groups and attend from one and one-half hours for the youngest group to three hours for the oldest group five times a week. Since these periods of attendance are so short, the authors naturally had no opportunity to handle the common problems of habit training that confront parents, and their observations on individual adjustment are therefore limited to difficulties found in the pre-school kindergarten. The usual nursery-to-upper-kindergarten forms of play, activities, apparatus, and equipment found in any modern school are available for these ages. The authors correctly stress the fact that younger children can perform the finer movements, but that fatigue should be avoided at all times. The next chapter, which deals with educational activities, presents nothing unusual in the development of literary appreciation, dramatic play, excursions, constructive activities, and the like.

In the chapter devoted to the social development of the children, several case histories are presented. The fundamental social attitudes revealed according to the authors are (1) treating playmates as objects; (2) assuming an adult attitude; (3) seeking attention; (4) doing as others do; and (5) coöperating with the group. These are discussed. A chapter of conclusions follows in which further experimentation is recommended on different age, social, racial, and other groups. The references are chiefly psychological. The appendices list stories, books, and songs for children along with selected phonograph records, physical-education and occupational-activity references, and names of supply houses for materials and apparatus. A guide for obtaining home information and an index are included.

The book is published in textbook style and some of the material is satisfactory, but hardly anywhere is it in keeping with the title of the text or the claims made for it. It appears to have been hurriedly thrown together and seems better suited to periodical publication. There is considerable confusion as to whom the book is actually intended for; certainly it will be of little use to most of those for whom it was prepared and who are named in the text. It does not supplant, to any great extent, some of the methods complained of in the introduction as "common-sense methods". Judging from the authors' remark on psychoanalysis (page 12), they apparently have little insight into this method or the existing literature in this field. Their limitations are also to be noted in the social-work field, for the sociological data of their children's histories are meager and the "guide" used is rather inelastic. Undoubtedly the laboratory activities had a beneficial socializing effect on the children, but little use is made of any method except that of social control. The question of individual motivations is not discussed and the important factors of family relationships, which account for certain individual variations in children, are neglected. Certainly the case histories in the book indicate that average and superior children have problems that differ little if at all from the younger clinic cases and that these are frequently the results of difficulties to be understood only by investigation of the family situation. The claim that permanent character is set in the pre-school child is a fatalistic statement somewhat surprising from the authors in view of their optimism about their own work.

The material on group play is interesting, but not original or peculiar to this type of group play. The discussion of physical growth is none too good a statement of the present status of this work, and when the question of remedy enters, the methods presented are inferior to those that we already have. There is very little in the book that is original and that is not already used in many centers throughout the

country by progressive educators in experimental schools. In fact some of the methods in the book have been improved upon.

Were it possible that the physical growth and the social and mental development of pre-school children could be so manipulated, over so short a period and with such simple means, as to insure physical, mental, and social adjustment in later life, we would all jump at the idea. But as a matter of fact, the matter is not so simple that we can apply a tape measure to the child and turn out perfect adjustments in later life. The book may be a suitable manual for those who are interested in equipping a nursery school and planning a program of activities. It certainly is not much of a contribution to our knowledge of child psychology in the broader sense of the term.

RALPH P. TRUITT.

The National Committee for Mental Hygiene.

SCHOOL AND HOME. By Angelo Patri. New York: D. Appleton and Company, 1925. 221 p.

In this book Mr. Patri has made a strong plea for the new education, the training of the child as an individual. He stresses constantly the fact that a child is in a different stage of being from an adult, that an adult can attain his best only if he has been allowed to develop through the ways of the child.

This plea is addressed to the parents of children in school and about to enter school. They are urged to inform themselves about the new methods and then to demand them for their children—to insist on the best kind of school and the best kind of teacher, irrespective of cost. Mr. Patri knows that if parents can be made to care enough, they will find the way. Many other people are saying the same thing, but few can say it with the same simplicity and vividness, the same wealth of apt illustration.

Mr. Patri's chapter headings are significant. He assembles his material with canny appeal. First there is *The Gifted Child*, in which Mr. Patri explains how, "driven by the gift", the child of unusual ability may easily be classed among the shy and dull because he is different. Mr. Patri declares that the American public school should do more than guarantee its children "equal opportunity for education and growth. . . . It should guarantee the right of the children to be as different as they wish to be. It should protect those differences, those gifts, as the sacred heritage of the race."

He goes on to say, in the chapter *The Child Who Fails*: "Nothing is more deadly to a growing intelligence than to check it and hold it up to mark time while the low spots in it catch up to the high spots. . . . Children do not grow that way. They are always jagged minded." He urges upon the school the use of programs that will

make failure impossible, since the grades will be elastic and so-called failures will be considered "a signal for help, not a mark of disgrace".

With deepest sympathy for blundering childhood, he shows in the chapter, *No Child Is Really Bad,* how codes of behavior have been formed by grownups, largely for their own convenience, leaving the children out of it. He calls the attention of adults to the uses of humor. "Child-training is difficult, subtle, a life work. There is no open road, no plainly marked chart. There is little to guide you but the vaguely expressed wants of the child and your own shrouded, muffled efforts to meet them."

In *Topsy-Turvy Education,* he discusses the lack of insight that makes a parent over-protective. "Every time the child is robbed of his struggle, he is cheated out of spiritual growth and power." He points out the futility of constantly interrupting what the child is doing and then expecting him always to finish what he has begun. The way for education to be "right side up" is to "put the children first".

The woeful lack of understanding of how children grow is stressed in *Sins Against Childhood.* In this chapter Mr. Patri makes the points that curiosity is the great lever to knowledge; that "each child is a unique personality"; that childhood is a stage of growth; that the child must have leisure for "dreaming, playing, creating"; that "nagging hurts him quite as much as beating him"; that exploiting him is unforgivable; and that nothing can do him more harm than lying to him.

"The training and discipline of children has to begin with the disciplining of the parents" is the thesis of the chapter *The Spoiled Child,* which gives some vivid examples of the genus.

The very bad effects upon children of the use of fear in discipline fill another chapter. While none of this material is new, it is especially adapted to parents who are bringing up their children in the unthinking "easiest way".

Mr. Patri uses the chapter *Parents' Associations* to show parents how they may best approach the schools to use their influence for a better understanding between school and home and to secure the partnership so desirable for both.

Mr. Patri brings to his task the wisdom of the experienced school man with a wit and understanding all his own. He not only convinces one that the education for which he pleads is desirable, but his enthusiasm and belief are so contagious that ideal school buildings, classes for twenty-five children, the school that has a personality and that respects the personality of every child, "big teachers", and parents who really understand, all seem almost within reach.

EDITH N. BURLEIGH.

Child Guidance Clinic, Los Angeles, California.

Sisyphos, oder Die Grenzen der Erziehung. By Siegfried Bernfeld. Vienna: Internationaler Psychoanalytischer Verlag, 1925. 164 p.

Dr. Bernfeld has thrown off the learned manner of his previous work on the psychology of the suckling and has written a stimulating book in a vigorous, untechnical style. From his psychoanalytic viewpoint, Dr. Bernfeld is able to see the limits set by man's nature and environment, without losing interest in education or hope that the individual may be educated. Indeed his book would be a tonic for disillusioned parents and teachers who are despondent just because they have built fantastic, impossible dreams of the unlimited power of education and of the child's nature. Dr. Bernfeld sees several reasons that account for the backward state of the science of education. Theorists like Rousseau, Fichte, Herbart, and Jean Paul lacked a wide experience of children as well as a clear insight into the child in themselves.

By education Bernfeld means all the suggestive influences to which children are exposed at home, in school, and in society. Among the constant limits to education Dr. Bernfeld stresses the dominant economic and social organization, on the one hand, and the emotional relation of love and hate between the educator and the child on the other. Though both emotions are manifest to his analytic insight in both sexes, he sees more evidence for the hate and envy in the male educator who, if savage, almost kills the boy at the initiation ceremony, and, if civilized, indulges in sadistic punishment. Maternal love is seen in its purest form in the customs that allow the newborn to develop in surroundings like those of the warm, dark, rhythmical rest before birth. Bernfeld's illuminating analysis at this point would have gained in clearness and value for the educator if, instead of viewing these facts merely in relation to the parents' and teachers' Œdipus complex, he had referred to the deeper unconscious envy and hostility to the child as a rival and to the unconscious, tender identification with it in both sexes.

Cavendish Moxon.

San Francisco.

Battling the Criminal. By Richard Washburn Child. Garden City: Doubleday, Page, and Company, 1925. 290 p.

This volume represents a very earnest and very ignorant effort to inform the public about "the great and growing shame of America", its "one preëminent national disgrace". No one would pay any serious attention to the book were it not for the fact that Mr. Child is a

member of the National Crime Commission, an organization with a worthy purpose and with some able members who must be much embarrassed by the swashbuckling poppycock which their associate has dashed off for public consumption in these chapters.

It would be unbecoming the psychiatric point of view to be angry or disgusted with Mr. Child's vehement scribblings. The facts of the matter are that he has very earnestly and laboriously written what the *Nation's* reviewer aptly describes as "a flashy and inaccurate book . . . by a cocksure criminologist". It is an emotionally surcharged harangue, pleading for the elimination of emotionalism! It bristles with exclamation points and rhetorical devices for emphasis and sensationalism.

For example, page 47: "This is a police byword in various parts of the country to-day—'Oh, sister, stop sobbing for the criminal; sob for his victim!'" Mr. Child does not explain what he means by sobbing for the criminal, but perpetuates this and other popular delusions in the conventional forms. There is much talk about coddling the criminal; social workers are ridiculed; the opponent of hard-boiled tactics is described as "the bearded gentleman"; doctors are "bought" and "hired".

There is much indulgence in newspaper slang and style, particularly of the cheap Sunday-supplement variety. A definite appeal is made to the imagination of the reader of this type of literature. As an example of this sort of serious essay writing on the part of an ex-United States ambassador and a self-elected student of the crime problem, consider the following:

"I stood behind a detective who had entered an all-night lunch room. The place was filled with riffraff which happened to be of a certain foreign blood—criminals, sneaks, heroin users, and painted girls. Because the detective insisted upon taking a concealed automatic from a cadaverous young man, the young man's companion arose in indignation.

"She was no more than sixteen, half clad and cerised of lips. Her little lean arms were bare; her neck beneath the shock of bobbed hair was thin and descended to a white flat chest. . . . She thrust forth her manicured, enameled hands like talons. Her brown eyes filled with vicious lights and her voice cracked in her piping soprano of anger. . . ."

Again, take this sample of a conservative and intellectual study of the crime problem:

"It was between midnight and one. A swift motor car whirled out of a side street, crossed the empty car tracks of a deserted avenue lined with closed stores below and dark tenement houses above, and

swung up to the curb in front of a brightly lighted all-night lunch room.

"Five active men leaped out of this car. They were young, and principally conspicuous by the suggestion of good-natured, eager, healthy youth. The moment they had started on a run across the sidewalk, six other men, who had been standing chatting in low tones in front of the plate-glass window, moved a step or two backward. One of these men had a white terrier dog on a leash. He was the man who exploded in the back of his throat two words of warning.

"He exclaimed in a low tone, 'The bulls!' "

To give Mr. Childs his due, it ought to be said that he does point out the weakness and slowness and uncertainty of court procedure and the numerous loopholes for the escape of the offenders. These points, however, have been made much better by writers who have not ruined their contributions by onslaughts against scientific efforts at the solution of the handling of the criminal, once corralled. This is a thing that Mr. Child seems not to understand at all, nor does he realize that he doesn't understand it. On twenty-three separate pages he belabors the psychiatrists, nowhere evincing any recognition of the fact that the handling of the criminal problem has never been in the hands of the psychiatrists. For the readers of *Mental Hygiene*, the following analysis of some of his criticisms will be interesting as representing the paranoid residuum that it is possible for a man of conspicuous public achievement to sell to the public in the year 1925 relative to psychiatry in its application to crime.

On page 161 he quotes a criminal as saying that few murderers were executed. "You will go to an insane asylum on the testimony of bought doctors."

On page 33 he says, "Some of our doctors have deluded us [whom?] into the idea that all crime is caused by adenoids or *glance* [glands?] abnormalities, so that any criminal can regard himself [implying that the psychiatrist is a criminal?] merely as a very sick man. [*Why merely?*] Some of our alienists and psychopathic experimenters [sic!] have made it possible for every highwayman's lawyer and every murderer's old mother to talk about [and why not talk about it?] the 'unfortunate abnormality of my client', or 'the complex which has seized my poor boy's mind'."

On pages 68 and 69 he refers again to the presumption that the psychiatric conception of crime is the result of wealth on the part of the criminal.

On page 196 he begins with a very characteristic phrase: "As one judge said to me—" All through the book some judge is saying to Mr. Child, or some famous criminal is confiding in him, or the chief of police of some unnamed city is telling him all the secrets. In this

particular instance the judge tells him that the criminal psychiatrists get criminals off and send them to Bermuda for pleasure trips.

On page 234 the psychiatrist is excused as being but the ignorant tool of the wicked lawyers.

On pages 256 and 257, Mr. Childs damns psychiatrists with the faint praise that it is not the psychiatrists who wish to examine the prisoners to find out why they should be restrained who throw "discredit on psychoanalysis [sic!] of prisoners", going on to say that "the silly aspect of the proposal, as so often stated, is that the discovery of abnormality is a reason for turning loose the abnormal, dangerous man. Discovery of abnormality in a man is not a reason for shortening his sentence or letting him go; it is an additional reason for committing him to safer keeping, and a new argument against his release from it."

In view of the fact that the psychiatrists have been proclaiming this point for a dozen years and have recently officially published it to all the world in the form of a report of a committee to their national association, there is no excuse for Mr. Child's pretending to contradict the psychiatric point of view and damning psychiatrists for not having the very attitude which they had taken long before it ever occurred to him. He repeats the same stuff on page 261, and the intervening pages are full of a diluted and pointless ramble along these lines.

Mr. Child lets himself in for what many people will regard as unconscious humor. For example, on page 63: "The most dispassionate and surprising unity of opinion as to the cause of lawlessness in our youth of to-day comes from the police." Again, "Many persons, knowing that I was to make a survey of crime, have written, 'Tell the remedy.'" (Page 263.) Again, on page 289: "'They ought to stop examining crooks for their insanity and take a look at you and me [a stupid, foiled detective] and all the rest of us.' In this statement, the officer properly placed the blame for the American crime tide [!] exactly where it belongs."

In short, Mr. Child has told the American public with much earnestness that things are in a bad way; that he has made a thorough investigation in the past few weeks and found the cause of it all, which is chiefly that the public doesn't care enough about its crime problem and that the psychiatrists care too much, because they are paid for caring. The remedy is to do something hard-boiled at once, but beware of scientists.

KARL A. MENNINGER.

Kansas Society for Mental Hygiene.

TRAINING THE TODDLER. By Elizabeth Cleveland. Philadelphia: J. B. Lippincott Company, 1925. 172 p.

The very tiny baby has long been a subject of concern. Many forces have combined to publish his needs and emphasize his importance. The child entering school at five or six comes again under careful observation; his well-being, both physical and mental, is the subject of a concern that is not only earnest, but intelligently trained. But what of the in-between time, the years from two to five? These years have been seriously neglected; there is less interest in this period of childhood and less information regarding it than any other.

Miss Cleveland points out how sadly inadequate is the average home to care for the needs of the toddler. His mother is usually occupied with the household routine and the care of the other children, including very likely a still newer baby, and has neither time nor strength left to devote to him, to teach him and play with him and help him to solve his problems of correct adjustment to the world. Even if she had the time and strength for such a task, she is usually pitifully incompetent to give him the guidance and stimulation he should have. Hence the child is most neglected at a time when he particularly needs care and attention.

One solution of this problem lies in the nursery school. This solution is the one that Miss Cleveland presents. Her book is, to use her own words, "an attempt to set down in the form of general principles some of the wisdom gained by contact with the children and teachers of the Merrill Palmer School of Detroit. Illustrated out of the experience of the nursery school in dealing with children between two and five, but applicable to other ages in schools or homes, arranged conveniently for the uses of groups of parents, classes of girls, or others engaged or interested in the training of little children." The Merrill Palmer School is an experimental school, established under the will of the late Mrs. Lizzie Merrill Palmer for the purpose of training girls for motherhood. Here there is every equipment for the comfort and care of the little ones. A nurse inspects them every morning before they enter the school rooms, a dietition prepares their meals, and sympathetic, carefully trained teachers direct their activities. The nursery school is in charge of an able psychologist, Dr. Helen T. Woolley.

Miss Cleveland describes in a chatty and readable manner some of the results obtained at the Merrill Palmer School. The physique of the children improves under its regimen of regular meals, play, and rest, its wholesome diet and careful physical supervision. How the mental development of the children is promoted is described from many aspects—sense training through play, vocabulary training through stories and dramatic games, training in artistic appreciation,

in craftsmanship, in concentration and interest. The section on emotional development is an interesting one. In a number of cases, serious problems in the emotional field have been remedied or greatly improved in the sane and helpful atmosphere of the school. Little Katharine's resistiveness and tantrums, for instance, disappeared when she found nothing to resist and no one to impress by her rages. Over-shy and over-bold children have improved under the social contacts of the group. Fears have been wiped away once they were intelligently analyzed. In matters of social development especially, the school has been able to accomplish much through the combined influence of teachers and playmates. Here, by virtue of its social contacts, the school has a great advantage over the home.

It has been possible to follow the subsequent school life of some of the children who have attended the nursery school. In nearly every case they entered kindergarten more independent, better able to adjust themselves to circumstances and meet their little problems, and in general somewhat better equipped socially and mentally, than children who had not had the pre-school training.

The nursery school is a challenge to the regular school to carry over into the teaching of primary grades more of the sympathetic attitude and careful and competent observation and supervision that characterize the nursery school, but it is still more a challenge to the regular school to unify its work with the life of the community better than it now does. Miss Cleveland suggests that the kindergarten, working with the parent-teacher associations, might do much to educate the community in matters of child care and solve many family and neighborhood problems.

Miss Cleveland's material is suggestive and stimulating rather than exhaustive. The book is profusely illustrated by anecdotes, most of which are excellently chosen. A few are almost too apt, so that one can scarcely help suspecting a bit of furbishing up. For instance, the story of the mother who replied to a comment on her son's tendency to slang with the remark, "Well, I've told the crazy little nut to cut that out!" is so suggestive of familiar old items from the joke columns that it sounds unreal and were better left out. The pictures are charming and add much to the attractiveness of the book, though some of the headings are more high-sounding than appropriate. But these defects are, after all, trivial, and it is perhaps because they stand out against the general excellence of style that they prove so annoying. For the book is for the most part written with real charm, and is most readable and interesting.

The book should be very effective in stimulating interest in the establishment in other communities of schools similar to the one described. It has also many valuable suggestions for the individual

mother or teacher, and the questions at the end of each chapter are stimulating. It is unfortunate that the title is not more accurately descriptive, for it suggests rather strongly that the book is for home use by mothers. This, of course, it is not primarily, although many of its suggestions should prove of value to the conscientious mother who is trying to do what she can at home for her child, in communities where no nursery school is available. The greatest service of the book should be, however, to encourage the spread of nursery schools. It is to be hoped that it will be widely read.

JESSIE C. FENTON.

Athens, Ohio.

EDUCATION, THE MACHINE, AND THE WORKER: AN ESSAY IN THE PSYCHOLOGY OF EDUCATION IN INDUSTRIAL SOCIETY. By Horace M. Kallen. New York: New Republic, Inc., 1925. 204 p.

Although not ostensibly a contribution to the mental hygiene of industry, this book, as indicated by its subtitle, deals penetratingly with the now much discussed mental and emotional attitudes of the industrial worker. The book throws no new light on the mental processes of the worker—does not pretend to do so. Its contribution lies in its definite suggestion of a type of labor education which, in the author's opinion, will be a means of so coördinating the mental life, the personality, of the worker with his work as to give suitable direction and outlet to those mental processes that now make for maladjustment.

Before giving his own view as to the nature of labor education, Professor Kallen quite convincingly portrays what labor education is not. In his opinion it is not to be found—has not been found to date at least—in public general education, which comes in for an extremely severe indictment at Professor Kallen's hands, as being dominated by capitalistic and other interests opposed to the interest of the working man. Neither does he believe that it is to be found in the so-called labor education that sprang up in so many places among the efflorescences of the post-war period. That this type of labor education "was labor education at all" was due, in the opinion of Professor Kallen, to "the accident that the cultured men and women whose passionate idealism carried it on were working in shops". This education was largely cultural. It provided channels of escape from the conditions of labor, but did not provide control over them.

Professor Kallen explains the psychology of the industrial worker in terms of compensation. The worker's habitual state of mind is one of boredom with his industrial enviroment; the tension of his machine-controlled work leads to nervous exhaustion; his half-con-

scious fear of losing his employment gives him a continual sense of insecurity; he works with a tool that is not his, and he fashions a small part of a product in which he takes no creative interest.

"In sum, the machine tender is in his spirit and sentiment an outsider towards the processes of industry." All this leads to setting the worker's job over against his life. "His personality is split, and the halves are opposed. What he spontaneously seeks from education is relevancy, not to the realities of his working day, but to its accompanying reveries." It is just this that most attempts at labor education to date have done. They have furnished the worker with a compensatory ideology, such as that contained in the socialistic creed, which has permitted him to run away from reality—a most unhealthy mental habit.

Professor Kallen's specific proposal as to the nature of labor education should appeal to mental hygienists. It is, as may be inferred from above, to teach the worker to face reality by giving him the type of education, technical and otherwise, that will enable him to exercise a genuine control over his industrial environment and find a spiritual and mental satisfaction, as well as a more adequate financial return, through such control. Professor Kallen points to the Baltimore and Ohio coöperative plan of shop organization as a concrete example of the genuine participation of labor in industry. This shop-craft agreement between the railway management and the machinists' union of the railway workers recognizes three fundamental principles:

> 1. The recognition of our unions as necessary, helpful, and constructive in the running of the shops, repair yards, and roundhouses.
> 2. The stabilization of employment.
> 3. The equitable sharing between shopmen and railroad of the benefit of coöperation.

A definite educational process was at the bottom of this successful experiment which gave a new attitude and habit pattern to labor. "With these changes, combat gives way to confidence, 'make work' and reverie to an awakened and self-gratifying 'creative impulse'; work and life are brought closer together."

Professor Kallen's own ideas as to the nature of labor education and what it should seek to accomplish are summed up as follows:

"Labor education would finally thus become conversant with control rather than escape. In such a conversancy more and more of the energies now seeking relief in the vapors of the social mechanisms of escape would find satisfactory enchannelment in the technique of control. The craftsman, having learned to see and to feel himself in the perspective of all the connections, human and material,

in which his job instantaneously sets him, would sense himself as the member of a great team working together, each in his place, to make excellently a good thing. His job would then acquire something of the symbolic character that being a soldier sometimes has in war; all his energies and interests would be integrated in it because it integrates all his relationships. He would feel them as the links of his fellowship with the entire working world; he would realize them as the channels of his freedom to reach out to this world. The more this vision and this feeling become a function of the day-to-day habit of work and responsibility, the more 'industrial democracy' would pass from a compensatory to a descriptive status."

STANLEY P. DAVIES.

New York State Committee on Mental Hygiene.

EUGENICAL STERILIZATION: 1926. By Harry H. Laughlin. New Haven: American Eugenics Society, 1926. 75 p.

The first state in this country to enact a law providing for surgical sterilization was Indiana. Since 1907, when that law was passed, twenty-three other states have taken similar action, nine states having enacted more than one such law each.

In this 75-page pamphlet Dr. Laughlin has presented an able summary of the various aspects of eugenical sterilization in the United States. The first section includes a general discussion of the subject, laying stress particularly on its legal implications. This section is followed by a chronological list of laws, amendments, vetoes, repeals, official legal opinions, board orders, and court decisions up to January 1, 1926. The third section presents an analysis by states of the various sterilization laws, including for each state the date of approval, basis of selection, type of operation authorized, underlying motive, and other topics. A statistical summary of operations performed, by institutions and states, constitutes the fourth section, followed by one devoted to the legal status by states as of January 1, 1926. The concluding section presents two "model eugenical sterilization laws"—one, the full text for a detailed sterilization law, and the other, for a short law.

One is impressed by the large number of sterilization laws that have been enacted and the small number that are functioning to any considerable extent. Of the 6,244 operations recorded, 4,636 were in California, 335 in Kansas, 313 in Oregon, and 262 in Nebraska.

In reading the statistical summary of operations, one should bear in mind that a large number are undoubtedly not of recent date. A few years ago, the reviewer inquired into the sterilization situation in this country by means of a brief questionnaire sent to the institu-

tions in the various states that came under the jurisdiction of the several sterilization laws. One item called for the number of operations performed at the institution during its last fiscal year, and another the total operations performed, by years, since the law's enactment. It was found that exceedingly few operations had been performed during the current year.

After the enactment of a sterilization law by any given state, operations are usually performed for a time. Then it frequently happens that the constitutionality of the law is questioned and it becomes a dead letter, although it remains on the statute books. In seven states sterilization laws have been declared unconstitutional. The New York law, which was enacted in 1912, was declared unconstitutional in 1918 and repealed in 1920. However, court decisions last year sustained such laws in Michigan and Virginia.

It is not surprising, in so comprehensive a study, to find omissions. For example, no reference is made to a law enacted in North Carolina (Chapter 281, Laws of 1919). However, it is interesting to find that a few sterilization laws enacted prior to 1922 that were omitted from the author's study of that year[1] have been included in the present volume.

The author is an earnest advocate of sterilization, which fact may account for his concluding this historical, legal, and statistical review with drafts of two "model" laws. After reading these laws, one questions whether with our present knowledge we are able to determine who is "a potential parent of socially inadequate offspring", or "a cacogenic person", as defined in these two proposed laws, and who, accordingly, ought to be sterilized.

As a source of information for persons interested in ascertaining what states have enacted sterilization laws and in obtaining a summary of the content of such laws, the book is exceedingly valuable.

EDITH M. FURBUSH.

The National Committee for Mental Hygiene.

ZUR PSYCHOLOGIE DER PHILOSOPHIE UND DER PHILOSOPHEN. By Alexander Herzberg, M.D. Leipzig: Felix Meiner, 1926. 247 p.

This book represents a contribution to the psychology of philosophy and of philosphers. The author, who is a well-known nerve specialist in Berlin, tries to answer the question: How does it happen that anybody formulates a systematic *Weltanschauung*—i.e., becomes a philosopher? He answers this question on a Freudian basis after an an-

[1] *Eugenical Sterilization in the United States.* By Harry H. Laughlin. Published by the Psychopathic Laboratory of the Municipal Court of Chicago, December, 1922. 502 p.

alysis of the following thirty eminent philosophers: Socrates, Plato, Aristotle, Epicurus, Augustine, Bruno, Bacon, Hobbes, Descartes, Locke, Spinoza, Malebranche, Leibniz, Berkeley, Hume, Rousseau, Kant, Fichte, Hegel, Spencer, Schelling, Herbart, Schopenhauer, Comte, Fechner, Feuerbach, Mill, Stirner, Hartmann, and Nietzsche. With regard to these "kings" among the philosophers, the following problems related to a psychology of "practical philosophy" are discussed: What is the attitude of philosophers toward professional work, money, love and marriage, social intercourse, and politics? In other words: What is their attitude toward matters of everyday life?

Herzberg draws the conclusion that his thirty philosophers dislike professional work and are unfitted for it; that twenty-seven of them show deviations from the norm; that they are unwilling and incapable of earning money (only Hume was a clever financier); that they have a distaste for marriage or are unfitted for it (only fifteen among the thirty married); that they dislike or are incapable of social intercourse, since only seven among the thirty do not show any pecularities in this respect; that most of them are politically incapable or not interested in politics. Thus in practical life philosophers are failures. For explanation of this efficiency in practical matters two hypotheses are presented—the "preponderance" hypothesis and the "inhibition" hypothesis. The author points out the inadequacy of the first, for which the preponderance of philosophical thinking is the *cause* of the practical inefficiency, and accepts the inhibition hypothesis, which explains the supremacy of philosophical interests as the *effect* of the practical inferiority. Such an inferiority is brought about by abnormally intense inhibitions. Most of the philosphers examined show a certain hypersensitivity to unpleasant experiences. Many exhibit psychopathic trends or are neurotics. In general, philosophy has three biologically important functions: (1) it is a surrogate for practical action functioning to discharge unused instinctive energy; (2) it substitutes for the repulsive and obstinate world of reality a painless world that can be easily mastered; (3) it is a roundabout way of gratifying a number of powerful interests.

Although the author adheres to the fundamental Freudian doctrines, he does not utilize all the psychoanalytical explanatory concepts that have a bearing on the subject of this study.

All who are convinced of the uselessness of philosophers will find this book is interesting reading. The question, however, whether philosophy itself is useless except from the standpoint of personal mental hygiene remains unsettled.

A. Klüver.

University of Minnesota.

A Health Survey of Eighty-six Cities. By the Research Division of the American Child Health Association. New York: American Child Health Association, 1925. 614 p.

The Research Division of the American Child Health Association has prepared an excellent report on many phases of the health work in cities of from 40,000 to 70,000 population. Nearly half of the book is taken up with sketches of the health activities in each of eighty-six cities, and one-third to analyses of administrative practices. The other sections deal with the conduct of the investigation and a proposed plan of organization of community-health work for a city of 50,000 population.

The programs of agencies other than the official city health departments are included in the survey.

The statistical presentation is a model of clarity and conciseness. The cities are grouped by thirds according to the American Public Health Association's appraisal-form scores in each of eleven major health activities.

The need is shown for more well-trained health officers who can give undivided attention to their tasks. Additional public-health nurses are also required. So-called sanitary inspections still consume an unduly large share of the health-department budgets. The average appraisal-form score obtained by the lower third of cities for the hygiene of the pre-school child is but 1 per cent of the maximum.

There is almost no mention of activities especially for the promotion of mental health. Reference to the *Directory of Psychiatric Clinics for Children in the United States,* published in 1925 by the New York Joint Committee on Methods of Preventing Delinquency, however, shows that twenty-six of the eighty-six cities have psychiatric clinics for children.

The American Child Health Association recommends that "special effort should be made to awaken in every community an appreciation of the importance of the pre-school years for the physical and mental health and social behavior of the child in his youth and in his maturity". Clinics for the pre-school child should deal with such problems as "faulty habits, antisocial attitudes, and speech defects, as well as physical defects".

The statement on page 15 that Dr. F. W. Sears of the New York State Department of Health developed a score card for rating city health work is erroneous. The score sheet referred to was produced by Dr. F. M. Meader in collaboration with Dr. P. B. Brooks of the New York State Department of Health in 1918.

On the whole, the *Health Survey of Eighty-six Cities* is a source of information which can be utilized readily by many persons for the promotion of the public health.

Archibald S. Dean.

New York State Department of Health.

The Utilization of Music in Prisons and Mental Hospitals. By Willem van de Wall. New York: National Bureau for the Advancement of Music, 1924. 67 p.

Dr. van de Wall has been for several years engaged in an effort to establish music among the definite therapeutic agents employed for the benefit of the mentally sick. Lately he has extended his work to include penal and reformatory institutions. The work is supported and to an extent supervised by a committee whose membership includes prominent psychiatrists. That the work has been useful we are assured by those who have watched its development.

In this volume of 67 small pages, Dr. van de Wall sets forth engagingly his ideas about the place and value of music in these institutions. His theses are stated in terms that represent the result of his varied experiences—some of which would have turned the energies of a less buoyant man into other channels.

The writer is temperamentally exuberant. Such phrases drop as "65 per cent of those released . . . commit worse crimes", supposedly because their prison associates have told them how, and on page 16 is a rather sweeping condemnation of disciplinarians and disciplinary institutions. Regarding this matter, one of conservative trend might question whether most of us would do much better in dealing with criminals than is now done. But let us agree that anything that offers improvement should be given the benefit of trial.

One who has seen Dr. van de Wall set out to get the coöperation of a large group of deteriorated women, and gradually win an enviable degree of quietness and participation in recitation and song, would accord nothing but respect to his dictum that music may activate reconstructive energies in a man, bring forth in him what is agreeable and good, and act as a socializing agent. "We do not claim", he says, "that music is a cure-all, or that a single cure or reformation can be credited to it as being all its own. It is simply a detail of the new work—that of salvage—now being undertaken in the old custodial human stockades. As such it plays a unique part efficiently."

On page 33 is a moving portrayal of one type of patient with whom we deal in mental institutions. The relation of her response to a musical approach takes one back to the days when Dr. and Mrs. Adolf

Meyer established such recreative and socializing services for the patients in Ward 27 of the Manhattan State Hospital.

The book will be read with interest and sympathy. The author has argued before the Music Teachers National Association that "the great field of musical service of the sick is in dire need of development. . . . It needs . . . artistic and moral conviction, but also patience and flexibility, idealism, and a fine sense of diplomacy and humor. I am sure that there are within the United States musicians by the score who would be well fitted or could be well prepared for this calling." This end may well be sought and may be no more illusory than the wish of a few years ago that athletic directors might be found for hospital work, a wish already fulfilled.

There is an excellent bibliography, covering several languages.

S. W. Hamilton.

Bloomingdale Hospital,
White Plains, New York.

William Crawford Gorgas; His Life and Work. By Marie D. Gorgas and Burton J. Hendrick. New York: Doubleday, Page and Company, 1924. 359 p.

This life of Gorgas is an interesting, chatty, and familiar narrative. It is well worth while, and of particular value to the interested lay reader, though it will not satisfy the student of history or of public health. Naturally it is somewhat rose-colored. At the same time it gives us a more intimate picture of the unofficial side of Dr. Gorgas than would come from a more impersonal historian. If it conveys any moral, it is that patience and persistence build better in the long run—and more enduringly—than strong-arm methods, though the latter may be more showy and produce quicker results. "Ambition without patience is just fireworks", and the present volume tends to bear out this saying. There were no fireworks in Gorgas' career, though much of a rich dramatic quality.

A. J. Lanza.

Metropolitan Life Insurance Company.

A study of Suggestibility of Children. By Margaret Otis. New York: *Archives of Psychology* No. 70, 1924. 108 p.

Suggestion has for a long time been an attractive field of research for numerous psychologists and psychopathologists. If their findings have not often been as valuable from a practical point of view as might be expected, it is not because the field has been unfertile. The reasons are to be found in the inability of the investigators, first, to isolate and measure the trait and, second, to learn what were

the influencing internal and external factors and how they operated upon it. Neither of these conditions was fulfilled in the present study. Yet it has contributed to our knowledge of both. Suggestibility has been measured through the statistical technique of correlation, but not in isolation. The effects of the variables of mental age, life age, and school grade were calculated, but not those of the immediate mental set.

The plan of the author was to obtain an index of suggestibility through group testing. The method was designed after the first page of the Army Alpha. Some of the test material was borrowed and some original, a number of the tests embodying the spirit and form of Binet's classical work on suggestibility. The directions were given orally, and the responses were written. Some of the suggestions were direct and some indirect. As a check on the directions test, the fidelity-of-report (*Aussage*) test was used. The first two chapters cover the question of the meaning and the history of the term suggestibility. The author finds that Woodworth's dynamic conception in terms of stimulus and response is the most serviceable. Freud uses the term, in two more recent works than the one quoted, not only in the sense of transference, but also as interchangeable with imitation and psychic contagion.

The remaining chapters take up the presentation, analysis, and interpretation of more than thirty tables, giving the results in such a detailed way that future workers can use them. Early forms of the tests are given, showing their development into the later ones. The data have been subjected to careful statistical evaluation and treatment. From the findings the author concludes that there is cumulative evidence, represented by a correlation of .65, that a definite trait of suggestibility was tested which is unaccounted for by the influence of mental age, life age, and school grade. The suggestions are arranged on a scale running from a degree of 95 per cent resistance to one of 6 per cent. Mental age was found to be the most important influencing factor, life age came next, and school grade was regarded as insignificant. In view of the fact that there is a pretty high relative correlation between mental age and school grade, it is not clear just why educational achievement falls so low. The author believes that the tests will be useful in indicating how a child ranks in suggestibility with reference to his mental level.

The difficulties that have made this trait elusive and unmeasurable are due to its dependence on a number of variable mental processes, among which the following are enumerated: comparison, reactions in the various senses, memory, memory images, mental set,

span of attention, and ability to suspend judgment and to weigh alternatives.

From the point of view of those who are engaged in changing human behavior, more complete knowledge about the mechanism of suggestion should be at hand. Observation and analysis of the social environment and the mental content that determine attitudes and mold behavior patterns are desirable in order to learn of the child's emotional and volitional processes. Up to the present time experimenting and testing have largely been concerned with stimuli and the direction of the responses. But investigations that aim to be of practical value will have to reveal something of the mental set. The author appears to realize that this is an important determining factor.

Furthermore, extreme degrees of suggestibility and resistance can be more properly interpreted if they are checked against actual behavior in daily life. Such measurements would then point to the probable force of suggestibility as a causative factor and would be of assistance in the application of principles of mental hygiene in the remedial treatment of children who show traits in the direction of misbehavior and delinquency.

A good test of suggestibility is needed, but there is none at present in general use. We should still like to know what the normal degree of suggestibility or resistance is. The part of the study that deals with delinquents should be much elaborated. In conjunction with some of the character tests of Voelker, Cady, and Raubenheimer, the scale ought to find a place in clinical procedure.

Richard H. Paynter, Jr.

The National Committee for Mental Hygiene,
Child Guidance Demonstration Clinic No. 1.

The Primary Problems of Medical Psychology. By Charles de Montet. Translated by A. Newbold. New York: William Wood and Company, 1922. 150 p.

This small volume is intended as a "textbook for students and practitioners" and is, one supposes, the substance of lectures delivered to his students by Dr. De Montet. But, as in the case of other presentations of the kind, the written word is not as convincing to the reader as the spoken word to the listener.

On first reading, one gets an impression of lack of system and vagueness of expression that will rather discourage the student who insists on definiteness in systematic descriptions, even though he may realize that such "definiteness does not exist in natural phenomena".

He will agree readily with Sir Humphrey Davy, who said: "Science or knowledge is the association of a number of ideas with some idea or term capable of recalling them to the mind in a certain order." In these days of crowded curricula, a textbook that gives a poor initial impression is likely to be impatiently cast aside.

Rereading considerably improves one's impression of the book and one feels that it well deserves a place as supplementary reading, to be delved into by student or practioner on occasions when he can take time for leisurely meditation over the many valuable ideas it has to offer.

The introduction is good, presenting a conception of what Dr. De Montet calls "reciprocal relativity" that would do much toward "redressing the balance" in the minds of students, who, unfortunately, seldom get any adequate idea of integration.

The section on primary conceptions, setting forth the author's views on consciousness and a refutation of the "unconscious" concept, is not satisfying.

The remaining portions of the book, although suffering here and there from obscurity in expression, are thought provoking and will lead the student along to a conception of the "multivocality" and interdependence of the life processes, so necessary in the business of living and in the practice of his profession.

The book does not meet the need for a short treatment of the subject for use by medical students in nursing schools or in schools of social work. It does, however, provide a good piece of reading for the time when the rush and hurry of undergraduate days are over and one has had more opportunity to view life whole, and perhaps has more leisure and desire to meditate on varying viewpoints.

A. T. Mathers.

Psychopathic Hospital, Winnipeg, Canada.

Experimental Investigations Into The Emotional Life of The Child Compared With That of The Adult. By Hilda Eng. Translated by George H. Morrison. London: Oxford University Press, 1925. 243 p.

Under her ambitious title, Miss Eng records the results of experiments upon 25 subjects—11 children and 14 adults. Measurements were made by the plethysmograph and pneumograph, and respiratory and volume-pulse curves were registered by the aid of a kymograph and Marey tambour. There is a minute description of the apparatus and technique of the experiment, with frequent references to the work of previous investigators. Some of these discussions are only indirectly connected with the problem stated in the title.

In a brief review, these finer points must be omitted without comment in order to give some idea of the major field. Passing on to this, we find that the respiratory and pulse-volume curves during feelings of pleasure and displeasure are interpreted from their mathematical aspects and in the light of introspective material obtained from the subjects. Taste, smell, and painful stimuli are most frequently used to produce the affective state called "the displeasure emotion". The first two stimuli give "fall in volume curve, decrease in pulse height, accelerated pulse rate, and retarded, deepened, and irregular breathing". The pain stimuli produce "fall in volume curve, decrease in pulse height, accelerated pulse, accelerated respiration". (Page 110.) Other smell and taste stimuli were also used to evoke "pleasure emotions". Here the smell stimuli are said to give "rising volume curve, increasing pulse height, retarded pulse, accelerated and shallow respiration". The taste stimuli cause "rise in volume curve, increase in pulse height, accelerated pulse; the respiration in one-half the experiments is retarded, but in as many cases it is accelerated". (Page 111.)

Miss Eng also describes curves recorded during what she calls "spontaneous" pleasure and displeasure emotions, which have been incited by the imagination or anticipation of the subject without the presentation of any sensory stimuli. The æsthetic emotions were investigated while the subjects read "masterpieces of literature or fairy stories", listened to songs and music, and so forth.

So far as a comparison of children with adults is concerned, Miss Eng states that in both groups the curves show similar changes with similar stimuli, indicating that the vasomotor and respiratory changes are the same in both. Spontaneous displeasure curves occur less frequently in children, however, and are of shorter duration with them than with adults. Conversely, "a relatively greater number of spontaneous pleasure curves are obtained from children than from adults". (Page 112.) The introspective material furnished by the subjects suggests that these spontaneous pleasure and displeasure emotions are somewhat differently aroused in children and adults, preoccupation with sensations characterizing the former and with personal experiences the latter.

In checking up her results with different theoretical formulations, Miss Eng does not consider her findings in harmony with the "pleasure-displeasure" theory, which limits the emotional life to these two, nor are her data any more in accord with the three-dimensional theory of Wundt. With regard to the James-Lange theory that all emotions are the outcome of organic changes, Miss Eng states that all her observations indicate just the opposite—that the emotions are

primary and the vasomotor and respiratory changes secondary. (Page 124.)

Miss Eng's terminology seems somewhat awkward to the reviewer, but this may be in part a result of the difficulties encountered in translating a scientific study from one language to another. We are more familiar with such terms as pleasure and pain, or pleasantness and unpleasantness, for example, than with the stilted phraseology "emotions of pleasure and displeasure". The influence of behaviorism, social psychology, and psychoanalysis tend to bring up connotations of researches into sex, anger, fear, and the like, in association with the word emotions. But the present author is not at all concerned with any of these (except incidentally with fright). Her book is a report of a piece of research in experimental psychology, following classical precepts of the laboratory.

PHYLLIS BLANCHARD.

The National Committee for Mental Hygiene,
Child Guidance Demonstration Clinic No. 1.

THE EVOLUTION OF ANATOMY. By Charles Singer, M.D. New York: Alfred A. Knopf, 1925. 209 p.

Here we have in book form the substance of the Fitzpatrick Lectures delivered at the Royal College of Physicians of London in 1923 and 1924. The field covered is that of anatomical and physiological discovery to the time of Harvey. Dr. Singer has reserved his consideration of the more modern period for another volume.

The history is appropriately divided into four parts. In the first we are told of the work of Greek anatomists up to 50 B. C. It is impossible to say just when or where anatomical knowledge began to be a matter of concern to men. The remains of pre-Greek civilizations, such as the Minoan, Mesopotamian, and Egyptian, clearly indicate close study of the surface contours of the body of man and even some fragmentary knowledge of the viscera, more especially the heart and uterus. There is some likelihood that the medical knowledge of the Egyptians was not so incomplete and unscientific as discovered documents might lead one to suppose.

One after another Alcmeon, who first describes dissections of animals, Empedocles, the forerunner of the pneumatic school, the philosopher Diogenes, the shadowy and elusive Hippocrates are mentioned briefly. Considerable space is given to a consideration of the Hippocratic collection, which, so often ascribed to Hippocrates himself, exhibits clear evidence of the work of many hands.

In the early Athenian period, the influence of Plato and Diocles are mentioned. The astounding observations and codifications of Aristotle are presented, and, as is natural, his anatomical errors are

pointed out. Herophilus and Erasistratus were the great beacon lights of the Alexandrian school, and their keen observations and accurate deductions and picturesque terminology, much of which survives to this day, are given adequate consideration.

The second section, entitled *The Empire and The Dark Ages,* is to a large extent taken up with a splendid account of the Prince of Physicians—Galen. A few interesting paragraphs are devoted to the medical interests of lay writers of the period—Cicero's elementary exposition of anatomy and physiology in the *De Natura Deorum,* Lucretius' ruminations on the physical construction of the universe, and the excellent work by Celsus, not himself a medical man, but apparently possessed of a decided "eye" for what was good in the earlier Greek writings. Pliny, of course, gathered together an immense amount of material, mostly superstitions and fictions, and the author dismisses him as a "voluminous, industrious, unphilosophical, gullible, unsystematic old gossip".

The section closes with a beautifully written note on the state of anatomy and medicine generally during the Dark Ages, that time when men's thoughts and fears were miserably torn between contemplation of the onward rush of the barbarians and the joys or terrors set forth in the new faith. "Who, then, would pause to consider this miserable tenement of clay?"

In the succeeding period, the center of medical science shifts eastward for a time, and while such noteworthy clinicians as Avicenna and Rhazes lived and flourished at this date, their interest in anatomy was apparently derived entirely from Galen. Then in the thirteenth century the great awakening came, and the results were soon evident in the field of anatomy. Post-mortems and dissections began to be made, at first only to confirm theories already held; but soon, as was to be expected, men's curiosity failed to be satisfied by any such meekness, and bold spirits speedily upset old beliefs and brought new facts to the light of day. Henri de Mondeville and Mondino worked and wrote, hastily and inaccurately often enough, but in a way that left no doubt of the new spirit that impelled them. Men discovered new facts, and what was also important, they began to reproduce them pictorially in a way hitherto unknown. The work of the great artists, Michelangelo, Dürer, and Raphael, shows how profoundly interested they were. That giant, Leonardo da Vinci, did much original work with the scalpel and his drawings illustrating osteology, myology, and angeology are superb. There is no doubt that from him Vesalius derived much in the way of inspiration and example. The appearance of books printed with movable type and of anatomical "fugitive sheets" was the outcome of greatly intensified interest and was in itself the starting point of still more diversified interests.

One cannot help being amazed by the work of Vesalius, who in his short fifty years performed such Herculean tasks. Dr. Singer's account of the great Reformer of Anatomy is highly satisfactory and he has most liberally interspersed numbers of the great master's finest illustrations.

But a review is no place in which to attempt the enumeration of the great anatomists of the period. One must read the book to see how splendidly they contributed. Two things strike one forcibly: first, the wonderfully accurate illustrations which the anatomists of this period provided, and, second, the slowness with which the renewed interest in anatomy and medical sciences percolated through into Europe north of the Alps. Right up to the time of Harvey, English anatomy and physiology remained almost entirely Galenic.

The last eleven pages of the text are devoted to the work of Harvey, which work really began the drift in point of view from *design* to *machine*. Harvey was a physiologist, not an anatomist, and, as the author points out, his chief scientific virtue was a negative one—the virtue of self-restraint. He was conservative, cautious, devoid of literary charm or gift. He sedulously avoided entering into barren philosophical speculation and debate, and carefully avoided making pronouncements until he felt that he could thoroughly justify them by his own works. His experiments, observations, and conclusions are concisely stated, as nearly as may be in chronological order.

The last seventeen pages of the volume are taken up with a valuable series of full-page nudes, skeletons, and muscle tabulæ from the *Epitome* and *Fabrica* of Vesalius.

There is no doubt that Dr. Singer has produced a splendid account of the growth of anatomical knowledge, and medical men interested in the backgrounds of their profession will find here not only a carefully prepared story, but one lucidly set forth and splendidly adorned. The publisher deserves more than a passing word of praise for his part in the production.

A. T. Mathers.

Psychopathic Hospital, Winnipeg, Canada.

NOTES AND COMMENTS

Kentucky

The 1926 legislature enacted a law providing for a bond issue of $5,000,000, the proceeds of which are to be used by the state board of charities and corrections for the acquisition of new property, and for new construction, equipment, improvements, and repairs at the various state institutions. This act was approved by the governor in March, and will be submitted to the voters at the November election.

The following provisions are quoted from Chapter 160, Laws of 1926—an act authorizing restoration to sound mind of persons who have been adjudged of unsound mind:

"Whenever it shall appear to the county or circuit court, from an affidavit filed, in which any person has been adjudged of unsound mind, that a person of unsound mind has been restored to his proper senses, or that the inquest was false or fraudulent, the court shall forthwith direct the facts to be inquired into by a jury in open court, and make all necessary orders and decrees in the premises. If the jury shall find the person charged who had heretofore been found of unsound mind, to be of sound mind, then the court shall enter an order and judgment restoring said person to his proper senses, and giving him all the rights and privileges of a person of sound mind.

"The proceedings instituted under this act may be by an affidavit filed by the person under investigation, or by his next friend, and if the person, so charged, has a committee the committee shall be notified of said proceedings by reasonable notice in writing, and the county attorney shall also be notified of said proceedings.

"The proceedings for restoration of the person to sound mind, who has been found of unsound mind, shall be commenced and proceed in the court in which he was adjudged of unsound mind, and both the circuit and the county court shall have jurisdiction to try cases under this act for the restoration of persons who have been adjudged of unsound mind, in their respective courts."

Massachusetts

The Department of Mental Diseases is authorized by Chapter 22, Resolves of 1926, to investigate the need for additional hospital accommodations, with particular reference to admissions from the metropolitan district. Among the items to be considered are the extent to which increased accommodations may be provided by enlarging existing hospitals, the feasibility of enlarging the Boston State Hospital either as a single state institution or by dividing it into two institutions, the suitability of land owned by the commonwealth in Waltham for a new institute, what additional land would be needed, and what revision should be made in building plans heretofore prepared.

The following instructions are contained in this chapter:

"The department shall also furnish statistics showing the annual increase of patients in its mental disease, epileptic, and feebleminded hospitals from the time the commonwealth took complete charge of public hospitals for such cases, and shall make a forecast of future probable growth, having in view the increase of the population of the commonwealth, the stricter immigration laws and regulations recently in force, the removal of veterans to federal hospitals, the development of preventive measures, extension of out-patient clinics and placing out on home care of patients, the possibility of more closely controlling the admission of persons whose mental condition does not require hospital care, and other factors bearing on the question."

In its report there is to be included also a brief statement of such information as is available concerning what other states are doing for their insane, feebleminded, and epileptic persons, annual expenditures, number of patients, standards adopted relative to per capita space, etc.

For the purposes of this resolve the sum of $1,000 was appropriated by the 1926 legislature.

Mississippi

The 1926 legislature enacted a series of laws providing for the removal of the state hospital from Jackson to the Mississippi State Penitentiary Farm at and near Howell and for a bond issue of $2,500,000 for this purpose. The entire farm site, consisting of over 3,000 acres, will be used for the state hospital, and the prisoners will be transferred to other penitentiary farms. The land and hospital buildings at Jackson will be sold.

Chapter 186, Laws of 1926, which amends the law relating to a convict under sentence of death who is found to be insane, contains the following new provision:

"In case such convict shall be found insane, the sheriff shall immediately transmit and deliver said convict to the state insane asylum, and a copy of the verdict of the jury and sheriff which made up an inquest to inquire into such sanity of said convict shall be sufficient authority for the superintendent of the state insane asylum to receive said convict as an inmate of said institution, and when the superintendent of the insane asylum so certifies to the governor that he is satisfied of the sanity of the convict, and the governor is so satisfied of the sanity of the convict, the governor shall order the sheriff to return said convict to the county where said crime was committed, and shall order, by his warrant to the sheriff, the execution of the convict on a day to be therein appointed by the governor according to the sentence and judgment of the court."

New Jersey

Chapter 269, Laws of 1926, amending the school law, among other provisions, authorizes county superintendents of schools to apportion to the rural school districts of their counties the sum of five hundred

dollars for each teacher employed in a special class for the instruction of children who are three years or more below the normal.

By the terms of Chapter 260, Laws of 1926, the medical superintendent or chief executive of any county institution for the care and treatment of the insane is given the power to arrest, without warrant, any inmate, committed thereto by a court of competent jurisdiction, who leaves such institution without having first obtained a parole or discharge. For the purpose of retaking such escaped patient, the superintendent or chief executive officer may go to any place within the state where such patient may be.

By the terms of Chapter 339, Laws of 1926, a tax of one-half mill on each dollar's value of real and personal property in the state is levied, for the purpose of paying the cost of "constructing, reconstructing, development, extending, and equipping state charitable, hospital, relief, training, correctional, reformatory, and penal institutions". Among the institutions to benefit from this tax are the State Hospital at Morris Plains, $447,500; the State Institution for Feebleminded, Vineland, $317,000; the Colony for Feebleminded Males, New Lisbon, $151,500; the Colony for Feebleminded Males, Woodbine, $65,000; the State Village for Epileptics, Skillman, $135,000; and the State Hospital at Trenton, $150,000.

New York

A psychiatric clinic at Sing Sing Prison has been provided for by the 1926 legislature. The general appropriation act includes $25,000 for equipping the new reception and classification building, which will house this clinic. Chapter 575 allows the sum of $15,000 for its operation. A full-time psychiatrist has been appointed, and is now selecting his staff.

The state-departments law, which reorganizes the various civil departments in the state government, as approved by the voters last year and enacted by the 1926 legislature, is amended by Chapter 584, Laws of 1926, by adding a new article relating to the department of mental hygiene. The head of this department is to be the commissioner of mental hygiene, to be appointed by the governor, by and with the advice of the senate. The department is to include three divisions: (1) the division of mental diseases, (2) the division of mental deficiency and epileptic diseases, and (3) the division of prevention. Each of these divisions is to be headed by an assistant commissioner, to be appointed by the commissioner. Other divisions may be established by the commissioner of mental hygiene. This department will have the jurisdiction, supervision, and control of the state hospitals, including Matteawan State Hospital, the state schools

for mental defectives, the institution for defective delinquents, and Craig Colony.

A new state hospital for mental diseases, to be known as the Rockland State Hospital, is established by Chapter 33, Laws of 1926. This hospital is to be located in Rockland County on a site heretofore acquired by the state under the provisions of a law enacted in 1925. An appropriation of $10,000 for maintenance is included in the new law.

A state psychiatric hospital at Syracuse University has been established by Chapter 346, Laws of 1926.

The state institution for mental defectives authorized by an act of the 1925 legislature has been designated by Chapter 44, Laws of 1926, as the Wassaic State School for Mental Defectives. This institution will be located in Amenia, Dutchess County. The new law appropriates $65,000 for maintenance and operation. This institution also receives an appropriation for further development from the proceeds of the 1923 bond issue to the amount of $2,600,000.

An appropriation of $1,000,000 was made by the 1926 legislature for fire prevention and safety measures at certain state hospitals and state charitable institutions.

Rhode Island

The Penal and Charitable Commission is authorized by a 1926 law to establish a children's bureau and appoint a chief executive officer to be known as the director of the children's bureau.

Virginia

A state farm for defective misdemeanants is established by Chapter 214, Laws of 1926. "Defective misdemeanants" includes "the tubercular, the venereal, the drug addicts, the inebriates, the psychopathic personalities and recidivists, and other persons mentally or physically defective who cannot be worked on the road forces", according to the terms of this law. Provision is made for the transfer of patients and prisoners from other institutions in the state, as well as for direct commitment to this new institution. Its control and management is vested in the state prison board, but the hygienic care and sanitation shall be under the supervision of the state board of health. The general purpose of the act, as stated, is "to provide employment, medical and mental care and treatment, discipline and control of prisoners committed thereto".

Chapter 517, Laws of 1926, relating to divorce, contains the following new provision:

"When the suit is for divorce from the bond of matrimony for wilful desertion or abandonment, it shall be no defense that the guilty party has,

since the commencement of such desertion, and within three years thereafter, become and has been adjudged insane, but at the expiration of three years from the commencement of such desertion the ground for divorce shall be deemed to be complete, and the committee of the insane defendant, if there be one, shall be made a party to the cause, or if there be no committee, then the court shall appoint a guardian *ad litem* to represent the insane defendant. This paragraph shall apply whether the desertion or abandonment commenced heretofore or shall commence hereafter."

Chapter 82, Laws of 1926, which amends an act relating to the commitment of inebriates to state hospitals for the insane, makes it compulsory that such inebriates be assigned and kept in wards apart from the insane patients. This law further authorizes the hospital board to designate one or more of the state hospitals for the care of inebriates, and when so designated, all such commitments are to be made accordingly.

A separate department for white idiots at the State Colony for Epileptic and Feebleminded, and a similar department for colored idiots at the Feebleminded Colony of the Central State Hospital, are created by Chapter 485, Laws of 1926. Prior to the enactment of this law, the statutes of Virginia have forbidden the receiving of idiots in any state hospital or colony.

The office of commissioner of state hospitals for the insane would be abolished by a joint resolution passed by the 1926 legislature. As this resolution is an amendment to the state constitution, it must be referred to the next general assembly.

Legal Aspects of Psychiatry

The following report was submitted to the American Psychiatric Association, at its Eighty-second Annual Meeting in New York City, by its Committee on the Legal Aspects of Psychiatry. The Committee, which was appointed early in 1925, consisted of Dr. Karl A. Menninger, Topeka, Chairman; Dr. William A. White, Washington, Vice-Chairman; Dr. L. Vernon Briggs, Boston; Dr. Bernard Glueck, New York; Dr. Herman Adler, Chicago; Dr. William Healy, Boston; Dr. Smith Ely Jelliffe, New York; Dr. Raymond F. C. Kieb, Beacon; Dr. Lawson G. Lowrey, Cleveland; Dr. Thomas W. Salmon, New York; Dr. Frankwood E. Williams, New York.

A preliminary report by this committee was submitted to the association at its 1925 meeting and later certain points of agreement and disagreement with regard to the various problems involved were reported in writing to the entire membership, with a request for an expression of opinion, so that the report might be revised to correspond to the prevalent attitude and convictions of the majority of the membership. The report as presented at this year's meeting was

accepted by the association, which ordered that the recommendations in their final and corrected form be placed in the hands of the council for a year and printed in the proceedings so as to reach all members of the association. The recommendations were also referred back to the committee with the request that they suggest to the council any changes they might desire and that they communicate with the American Institute for Criminal Law and Criminology and other bodies working along similar lines. The report is given below:

The committee felt that the problem assigned them was not merely one of what we as psychiatrists should recommend to the lawmakers in regard to bills regulating expert testimony. It seemed to us that our problem was one of reinterpreting to society the function and the objectives of the psychiatrist, particularly in so far as these concern the type of behavior which is technically and popularly regarded as criminal. The committee felt that it was exceedingly important to divert the attention of the public from the relatively minor issue of *alienistics* to the major issue of *psychiatrics.*

In the practical application of psychiatry to problems of criminal law, the prevalent concepts of tradition and long usage conflict sharply with psychiatric attitudes. Popular theories of retribution and established methods of dealing with offenders almost entirely prevented a scientific envisagement of crime until recently when psychiatrists, in spite of their original limitation of field, discovered and demonstrated that types and trends of abnormal psychology extended far out from the asylum into the courtroom, school, and home. The psychiatrists found their experience and technique equally applicable to the irascible employee, the retarded school child, the persistent stealer, the compulsive drinker, the paranoid murderer, and the textbook cases of epilepsy, melancholia, and schizophrenia. Face to face with the legal partitions of misbehavior into "insane" and "criminal", psychiatrists now find themselves with no technical interest in these partitions and no general agreement with them, but with a driving concern in all the unpropitious trends of human character; with all acts, thoughts, emotions, instincts, and adaptations, either socially or individually adverse. Some of these constitute committable "insanity", some of them do not; but all of them are psychiatric problems.

The question of responsibility is constantly being raised, and the psychiatrist is frequently asked to make definite statements regarding the responsibility of a particular subject. As White and Glueck have shown, however, the conception of responsibility is exceedingly vague. In a strictly legal sense it means the capacity to change one's conduct in response to the direction of certain painful associations. Of course this is not the sense in which the public understands it or uses it. In the latter case it is merely an echo, the antiquated crystallization of primitive and infantile reactions known as talion law. Of course no scientist has a moment's consideration for such emotionally determined policies or mystical concepts of atonement. There was a time when even inanimate objects were held to this kind of accountability. If a man tripped over a chair and injured himself, the chair was "responsible", and must be punished by being burned or broken. Until comparatively recent times animals were held responsible for injuries they committed; they were tried and convicted and formally sentenced. But ultimately inanimate things and animals came to be exempted from the ritual of responsibility, and slowly, but progressively children, idiots, and finally most of the "insane" were likewise exempted. Various curious tests then had to be decided upon to determine the "responsibility" of persons suspected of "insanity" (or an "irresponsible" "insanity"). Once they were compared

in appearance and conduct with wild beasts, later with the "mentality" of a fourteen-year-old child. This was actually the criterion of "responsibility"! Current even to-day in many states is the slightly less hoary "right or wrong" test, persisting in spite of common knowledge that people are actuated by various compulsions to do things they themselves regard as wrong in the most shameful sense. Psychiatrists realize that the capacity to feel remorse does not imply power to control conduct.

The legal problem of responsibility evidently involves the philosophical problem of "free will". Philosophy still debates the different issues of the question, and science can hardly assume to give a final answer to them now. But the law stubbornly maintains that the question is closed. According to the law, all persons of certain categories possess absolute freedom of will, and all persons of other categories possess none. Neither science nor philosophy can accept such a conclusion.

The scientist, then, really cannot answer as to legal "responsibility", and he does not wish to participate in the ritual of "punishment". (Several members of the committee emphasize our professional interest in observing how it gratifies the craving of the crowd for atonement through vicarious suffering.) For his patients the psychiatrist seeks, not retributive action, but diagnosis and scientific attempt at therapy. This, in a sense, is an "inhuman" attitude, in that it is a departure from the instinctive mechanism that rules most of humanity; the clamor for vengeance is more "human". But treatment may sometimes be as painful as the sacrifice prescribed by the legal ritual. Opening a boil or setting a fracture may be painful, and the psychiatrist, too, may prescribe painful treatment, but it is never punishment (retributive).

The committee felt, therefore, that the bill covering the question of criminal responsibility was a problem upon which there was at the present time insufficient information and insufficient general agreement. Most of the members of the committee felt that the word "responsibility", as well as the word "insanity", and other similar static concepts should be eliminated entirely and endeavor made to determine rather the capabilities and incapabilities of the accused, or a specification of whether or not the mental status (disease, defect, trend, etc.) of the offender was likely to lead to neglect or danger to himself or to others.

For this reason the proposal of the American Institute for Criminal Law and Criminology was not wholly approved. It was regarded as a good beginning step, but it has two flaws, one of which is that it perpetuates the ambiguous and metaphysical term "responsibility"; the other is that it insists upon a particular state of mind without being able to define it. The committee has given careful attention to Sheldon Glueck's excellent book on mental disease and the criminal law[1] and recommends it to the study of all members as a presentation of the legal status of various problems involved, without particularly favoring the author's specific recommendations for legal reform.

With regard to the burning question of expert testimony, the committee was in almost unanimous agreement that the recent Massachusetts laws offered the best practical technique so far presented. The committee is favorably impressed by both the Massachusetts and California laws. Various defects will no doubt appear; it is perhaps questionable whether sufficient examination is provided for and whether there is sufficient latitude for recommendations. Psychiatrists certainly do not wish to be limited to "Yes" or "No" reports, *i.e.*, to specify whether or not a man should be sentenced. It is rather a question of how he should be handled, where he should be kept, or what he should be given

[1] *Mental Disorder and the Criminal Law*, by S. Sheldon Glueck. Boston: Little, Brown & Company, 1925.

to do. The problem of sufficient remuneration is another question involved to which the committee had no time to give. That these laws have faults is certain, but they represent an enormous step in advance, and they anticipate nearly all of the defects and faults of the present system of expert psychiatric testimony in criminal trials. Whatever the precise legal procedure adopted, the committee felt it imperative that all judges be authorized (obliged) to request psychiatric advice, the examinations to be made conjointly, the reports to be made in writing, and the remuneration to be made from public funds.

The committee unanimously favored an attempt to codify the commitment laws of the various states. "Insanity" has come to mean nothing but certifiability—*i.e.*, the desirability of enforced hospitalization. It seems quite unnecessary to have a score of different methods for determining the desirability of this step. The committee recognizes, however, the great practical difficulties in achieving this codification and has no specific ways and means to suggest. . . .

For the present, your committee specifically recommends the following proposals for immediate action:

1. That the American Psychiatric Association go on record as favoring certain types of legislation such as the recent Massachusetts enactment which put the psychiatrist in a position of counseling the legal authorities as to the disposal of social offenders.

2. That the American Psychiatric Association set up, agree upon, and publish official standard qualifications of medico-legal experts, and that it maintain a published list of such qualified experts, revised annually, for the convenience of court selection.

3. That the American Psychiatric Association, in its annual conventions, give more attention to the problem of psychiatry as applied to crime and other behavior disorders, including demonstrations of the work being done in penal and correctional institutions, behavior and child-guidance clinics, and psychiatric clinics associated with criminal courts.

4. That the American Psychiatric Association foster an attack on certain pressing problems of research in this field, particularly (a) the working out of a useful nosological classification of mental disease which will take into consideration behavior pathology not now definitely defined or classified from a psychiatric standpoint, and (b) the analysis of the medico-legal situation in the various states of this country with particular reference to psychiatry.

5. That the American Psychiatric Association advocate the association of a psychiatrist or a psychiatric clinic with every penal institution and with every criminal court, to act in an advisory and consulting capacity without administrative duties, and that it advocate the teaching of courses in criminology in both law schools and medical schools by psychiatrists.

6. That the American Psychiatric Association maintain a central bureau, either in the form of a standing committee or in the form of a full-time paid secretary, to aid in disseminating to the medical and lay public, in a dignified and accurate manner, news of the actual and potential contributions of psychiatry to present-day social life, perhaps coöperating with The National Committee for Mental Hygiene. Such a bureau should publish from time to time an official bulletin containing official statements of psychiatric attitude and opinion available to newspapers, magazines, and the public at large.

7. That the American Psychiatric Association officially accept, endorse, and subscribe to the following statement of the present attitude of the members of this association toward the problems now under consideration and give it wide circularization:

OFFICIAL STATEMENT OF POSITION

We believe—

1. *That* the psychiatrist's chief concern is with the understanding and evaluating of the social and individual factors entering into failures in human life adaptations.

2. *That* crime is a designation for one group of such adaptation failures, and hence falls definitely within the focus of psychiatry, not excluding of course, certain other branches of science.

3. *That* crime, as well as other behavior and characterologic aberrancies, can be scientifically studied, interpreted, and controlled.

4. *That* this study includes a consideration of the hereditary, physical, chemical, biological, social, and psychological factors entering into the personality concerned throughout his life as well as (merely) in the specific "criminal" situation.

5. *That* from a study of such data we are enabled in many cases to direct an attack upon one or more of the factors found to be active in a specific case to effect an alteration of the behavior in a propitious direction; while in other cases where this is not possible, we are able in the light of past experience and discovered laws to foresee the probabilities to a degree sufficient to make possible proper provision against subsequent (further) injuries to society. By the same experience and laws we are enabled in still other cases to detect and endeavor to prevent the development of potential criminalty.

6. *That* these studies can be made with proficiency only by those properly qualified—*i.e.,* scientists who have made it their life interest and study to understand and treat behavior disorders.

7. *That* this point of view requires certain radical changes in legal procedure and legislative enactment, insuring the following provisions:

a. The court appointment, from a qualified list, of the psychiatrists testifying in regard to the mental status, mechanisms, or capabilities of a prisoner; with opportunity for thorough psychiatric examination, using such aids as psychiatrists customarily use in practice, clinics, hospitals, and so forth; with obligatory written reports, and remuneration from public funds.

b. The elimination of the use of the hypothetical question and the terms "insane" and "insanity", "lunacy", and the like.

c. The exemption of the psychiatrist from the necessity of pronouncing upon intangible concepts of religious and legal tradition in which he has no interest, concern, or experience, such as "responsibility", "punishment", and "justice".

d. The development of a machinery adequate to the requirements of the psychiatric point of view in criminal trials and hearings, including court clinics and psychiatrists, and ultimately a routine compulsory psychiatric examination of all offenders with latitude and authority in the recommendations made to the court as to the disposition and treatment of the prisoner.

8. *That* this also entails certain radical changes in penal practice, including:

a. The substitution of the idea of treatment, painful or otherwise, for the idea of retributive punishment.

b. The release of prisoners upon parole or discharge only after complete and competent psychiatric examination with findings favorable for successful rehabilitation, to which end the desirability of resident psychiatrists in all penal institutions is obvious.

c. The permanent legal detention of the incurably inadequate, incompetent, and antisocial, irrespective of the particular offense committed.

d. The development of the assets of this permanently custodial group to the point of maximum usefulness within the prison milieu, industrializing those amenable to supervised employment, and applying their legitimate earnings to the reimbursement of the state for their care and maintenance, to the support of their dependent relatives, and to the reimbursement of the parties injured by their criminal activities.

9. *That* effective preventive medicine is applicable in the field of psychiatry in the form of mental-health conferences and examinations, child-guidance clinics, mental-hygiene clinics, lectures, and literature, and similar institutions and efforts.

10. *That* the procedures outlined provide an efficient and scientific solution to the problems of crime, viz:

a. The protection of society.

b. The rehabilitation of the "criminal" if possible.

c. His safe and useful disposition or detention if rehabilitation is impossible.

d. The detection and the prevention or deflection of the development of criminality in those potentially predisposed.

College Men and the Birth Rate

The following report of an inquiry as to the attitudes of a group of college undergraduates on the subject of the size of the family appeared in a recent number of the *Journal of Heredity*. As the authors, Stuart A. Rice and Malcolm M. Willey, point out, the replies are interesting as an index of the trend of thought in the class represented by these students.

"There have been in recent years numerous statistical studies showing the tendency of the birth rate among the intellectual classes, and particularly among college graduates and among families from which college students are recruited.[1] All of these have shown a downward movement and make it clear that the college groups, speaking broadly, are not reproducing themselves. Significant as these studies are statistically, most of them have not indicated what the individuals in these same college groups were thinking in reference to the size of American families. To a large extent, the approved size of the family in any age is closely bound up with what the sociologists have called the *mores* of the group—types of behavior which have received the stamp of social approval. These change from generation to generation. The individual of any period absorbs the *mores* with which he is surrounded from the time of his birth, and his opinions, whether the result of rational thought or not, tend to reflect the *mores* of his time. Present and future tendencies with respect to the birth rate must, therefore, be considered in the light of imperceptible changes in the *mores*. It is apparent that the birth rate is more and more becoming a function of conscious reflection, but the latter is in the nature of a conscious adaptation to *mores* that have been accepted uncritically.

[1] See, for an excellent example of the latter, the study by Dr. S. J. Holmes in the *Journal of Heredity*, October, 1924.

"In view of these considerations the attitudes of a selected number of college undergraduates toward the size of the family will be of some significance. The occasion for an inquiry among their students along these lines recently came to the writers in connection with a picture published in the rotogravure section of one of the Sunday papers. This showed a prosperous middle-class family consisting of two parents and seventeen children. The students whose attitudes were sought, 130 in all, were members of an introductory course in sociology at Dartmouth College. In groups averaging 20 in number they were shown the picture and asked to set down first their immediate unthought reaction to the family situation represented. Immediately following they were asked to describe in more detail their emotional response upon seeing the picture. Finally they were asked to reply to this question: In your daydreams of marriage, do you visualize children; if so, how many?[1] The replies were anonymous.

"Several striking uniformities of attitude can be seen in these replies. In the first place, a majority of the answers could be classified into two well-defined and sharply opposing points of view. In numbers they are about equally balanced. On the one hand, strong approval and commendation were expressed. On the other was disapproval, often accompanied by extreme disgust. Of the first type the following expressions are typical:

> "'It appeals to me very much. * * * I think it is ideal to have a large family. * * * I wholeheartedly commend the parents.'
>
> "'It always gives me a peculiar pleasure to view a large family such as this.'
>
> "'It must be wonderful to belong to a family like that.'

"In contrast:

> "'I may be very foolish to react this way, but large families have always aroused disgust in my mind.'
>
> "'It may be that I have an inherent bias against large families, but this picture does certainly irritate me.'
>
> "'My first reaction is one of repugnance. A family of such size seems immodest. * * * My reaction is one of disgust.'

"Another well-defined attitude centers around the mother. This can best be expressed as a feeling of consideration for the physical pains undergone in childbirth, and the sacrifices and hardships attendant upon the rearing of a family. It is evident that most of these young men feel thoroughly reluctant to subject any woman to the hardships entailed in childbirth. They are weighing carefully these hardships against the desire for and the responsibilities of parenthood. This attitude is well illustrated in the following:

> "'I can't imagine the immense amount of pain a woman must have suffered in bearing those children.'

[1] In two groups this question was not asked.

"'The burden of the mother in bearing each and every one of 17 children irritates me.'

"'A man can't love his wife to cause her to give birth to so many children. The pain and suffering involved is so terrible that many loving couples have no children. And this man has 17 or 18!'

"The answers relating to their own daydreams of marriage and resulting children are illuminating:

"Seven only of 90 men to whom the question was put stated that they had no such daydreams. Of the remaining 83, 82 admitted a visualization of children. One man only expressed a desire for a childless marriage. Three were indefinite concerning the desired size of their dream family, but the remainder were specific, the distribution being as follows:

No. of children desired	No. of men
0	1
1	2
2	38
2 or 3	9
3	15
3 or 4	3
4	6
4 or 5	1
5	3
5 or 6	1
10	1
	80

"It is readily observed that 62 among 80 men expressing a specific preference desired a family of either two or three children, which, according to accepted authorities, is not enough to reproduce the group represented.[1] It is interesting to note that the number of children preferred bore no relationship to the attitude expressed toward large families. Even those most laudatory in their praise and admiration of the family whose picture was shown, in so far as their own personal desires for two or three children are concerned, are in complete accord with those who disapproved of this same large family. Alike in their own wishes for a small family, the two groups differ only in toleration of those who have large ones.

"It is clear, to the extent that these students are representative of the coming generation of college-bred parents, that families of a size less than sufficient for the perpetuation of their class meet the approval of the group *mores.*"

[1] L. I. Dublin, *J. Am. Statis. Assn.*, March, 1925. Dr. Dublin calculates that on the average, 3.1 child per married couple having children are needed to preserve a constant population in the group. He also states that one marriage in six is childless. *Cf.* Holmes, *op. cit.* "It is, therefore, a matter of doubt if with our present death rate, an average of 3.5 children would suffice to reproduce the general class of fairly well-educated people who supply our college students."

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GENERAL PURPOSES

The National Committee for Mental Hygiene, directly and through its affiliated state societies and local committees, works for the conservation of mental health; the reduction and prevention of mental and nervous disorders and defects; the improved care and treatment of those suffering from mental diseases; the special training and supervision of the feebleminded; and the acquisition and dissemination of reliable information on these subjects and on mental factors involved in the problems of education, industry, delinquency, dependency, and others related to the broad field of human behavior. The committee seeks to accomplish its purposes by stimulating research into the nature and causes of nervous and mental diseases and defects; conducting surveys and studies of mental-hygiene problems; applying the knowledge gained from such studies, through education and the promotion of beneficial legislation; encouraging psychiatric social work; establishing child-guidance and other mental-hygiene clinics; developing trained personnel; and coöperating with governmental and unofficial agencies whose work touches at any point the field of mental hygiene.

When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.

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